

**MIDTERM EVALUATION
OF THE
LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS
INITIATIVE**

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ACRONYMS AND FOREIGN TERMS

ACS	Agente comunitario de salud (community health agent)
AIEPI	Atención Integrada a las Enfermedades Prevalentes de la Infancia (IMCI)
AIN	Atención integral al niño (integrated attention to the child)
ARI	Acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival Project
CDD	Control of diarrheal diseases
CCH	Community and Child Health
COMSAIN	Comunicación en Salud Infantil (Communications in Infant Health)
COTALMA	Centro de Capacitación para la Lactancia Materna y Nutrición (Training Center for Breastfeeding and Nutrition)
CTO	Cognizant technical officer
EPI	Expanded programme on immunization
G/PHN	Bureau for Global Programs, Field Support and Research Center for Population, Health and Nutrition
HIS	Health information system
HN	Office of Health and Nutrition
IMCI	Integrated management of childhood illness
IMR	Infant mortality rate
IR	Intermediate Result
LAC	Bureau for Latin America and the Caribbean
LACI	LAC Regional IMCI Initiative
M&E	Monitoring and evaluation
MINSA	Ministerio de Salud (MOH)
MOH	Ministry of Health (recently renamed Secretary of Health in Honduras)
MSH	Management Sciences for Health
NGO	Nongovernmental organization
PAHO	Pan American Health Organization
PCMI	Proyecto de Capacitación Materno Infantil
PROCOSI	Programa de Coordinación en Salud Integral (Coordination in Integrated Health Program)
PVO	Private voluntary organization
R4	Results Review and Resource Request
RPM	Rational Pharmaceutical Management
RSD	Office of Regional Sustainable Development
SO	Strategic Objective
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

In the 1980's, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) developed the strategy, integrated management of childhood illness (IMCI). The objective of IMCI is to decrease morbidity and mortality from common childhood illnesses through the application of a low-cost strategy that identifies and treats life-threatening illnesses more quickly than through traditional vertical disease control programs. The IMCI strategy encompasses a range of interventions for the prevention and management of major childhood illnesses, both in health facilities and in the home. It incorporates many elements of diarrheal disease and acute respiratory infection (ARI) control programs and child-related aspects of malaria control, nutrition, expanded programme on immunization (EPI), and essential drugs programs. According to WHO, implementing the strategy requires and facilitates active collaboration among these programs and requires efforts at different levels of the health system.

In the Americas, the United States Agency for International Development's (USAID) Bureau for Latin America and the Caribbean (LAC) developed a five-year, \$5 million regional activity for more effective delivery of child health services in response to the control of diarrheal disease (CDD), ARI, and malnutrition. This program, the LAC Regional IMCI Initiative (LACI), has been implemented through two partners, the Pan American Health Organization (PAHO) and the Basic Support for Institutionalizing Child Survival Project (BASICS), since its authorization in March 1997. The eight countries selected for emphasis, based on their high infant and child mortality rates, were Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, and Peru. In the late 1980's, these countries were designated by LAC for emphasis in child survival programming.

A midterm evaluation was conducted to review the USAID Results Framework, evaluate overall progress to date, identify major accomplishments and barriers, and propose recommendations for midcourse corrections. A 2-person team conducted 1 week of interviews in Washington, D.C., beginning in early April 2000. Field work then commenced and involved visits of 1 week each to three of the eight target countries: Honduras, Bolivia, and Peru.

A. ACTIVITIES FUNDED

LACI took on a supporting role for introducing IMCI in the eight target countries. PAHO and BASICS managed independent budgets and activities from a joint work plan. Examples of the use of LACI funds include:

- advocacy to convince countries to adopt IMCI as policy;
- adaptation of WHO's generic IMCI materials for use in the different countries;
- selected in-country activities that had regional implications (e.g., introduction of the rational pharmaceutical management tools and manual);
- regional meetings to address specific issues and for annual information sharing; and
- two national evaluations (Bolivia and Peru).

Because of the nature of the activities supported by the LACI, a measure of their effectiveness is the degree and quality of the implementation of IMCI at the national levels.

B. FINDINGS

Findings regarding the Results Framework and progress to date include:

1. **Strategic Objective level:** As presently stated, the two indicators are not appropriate for the initiative, although significant progress towards achieving the goal was observed by the evaluation team.
2. **IR 1 (IMCI information and policy adoption) and IR 2 (national IMCI operational plans):** Substantial progress has been achieved; seven of eight countries have adopted IMCI and have developed plans.
3. **IR 3 (improved country capacity):** The indicators need revision; considerable progress has been achieved.
4. **IR 4 (use of monitoring and evaluation):** The indicator needs revision; progress is being hampered by the low use of appropriate tools.

Based on the findings of this evaluation, the LAC Regional IMCI Initiative has made substantial progress. A summary of the progress to date is provided in the tables on the following two pages. Table 1 summarizes aspects of implementation that are working well, suggests the reason(s) for this, and provides specific examples from the countries visited. Table 2 describes aspects of implementation that are not working well, suggests the reason(s) for this, and provides recommendations.

Table 1: Aspects of Implementation that are Working Well

Which aspects are working well?	Why?	Examples
1. USAID/LAC's Role as a Catalyst	Activities are well chosen for catalytic role	Regional meetings and conferences stimulate crossfertilization of ideas; training of facilitators out-of-country stimulates training activities in-country
2. The Partnership	Generic roles for PAHO and BASICS are appropriate; play to their strengths; annual meetings (PAHO, all partners)	PAHO is the natural counterpart to the Ministry of Health (MOH) in-country; BASICS is the natural connection to USAID Missions and the Global Bureau*
1. Involvement of the Ministries of Health	LACI was perfect fit for MOH's emphasis on decentralization and need for improved quality of health services	LACI complements MOH's own contributions of human, financial, and physical resources to IMCI
4. Creation and Translation of Tools	Right tool(s) in the right place (Latin America) at the right time	All 3 countries visited are using materials translated for Latin America from generic WHO, PAHO, and BASICS materials
5. Expansion of IMCI	Due to early implementation success of IMCI, the training component has attracted additional financial support; general drug availability at most health centers supports expansion	Financial support for expansion is available in Honduras—USAID/Honduras; Bolivia—USAID/Bolivia, for community IMCI, World Bank; Peru—World Bank, Proyecto 2000; nongovernmental organizations (NGOs) in 3 countries (e.g., CARE—Honduras, Plan International—Bolivia and Peru)
6. Quality of Clinical Training	High-quality and locally adapted training guides, manuals, and supporting materials; selected cadre of trained facilitators	Enthusiasm expressed by hospital directors, facilitators, participants (nurses, doctors), promoters, mothers
7. Intersectoral Collaboration (health and education)	Opportunities to reinforce content and channels of communication	Peru: The health center at Cura Mori, Piura, has developed a mutually reinforcing relationship with teachers at local schools for health education and promotion (e.g., teaching hygiene, sanitation)
8. Community Participation	Strong consensus on need for working at community level with promoters, mothers, extended families about nutrition and danger signals	Close and mutually respectful partnership between NGOs and MOH to implement IMCI at the community level; builds on NGOs' proven expertise

*Global Bureau = Bureau for Global Programs, Field Support and Research

Table 2: Aspects of Implementation that are not Working Well

Which aspects are not working well?	Why?	Recommendations
1. Central (D.C.–based) managerial structure (the steering committee) does not meet expectations	Personnel turnover (USAID/LAC and BASICS); selective delegation of authority to steering committee; members' roles and responsibilities not sufficiently delineated from the beginning	More authority to steering committee (along lines of Health Sector Reform Initiative); practice team building with an outside facilitator; prepare a detailed implementation plan for rest of project, including better delineation of roles and responsibilities; appoint a partner with overall coordinating role for LACI in each country
2. SO indicators are not appropriate for regional initiative	One donor (LAC) cannot be responsible for indicators which reflect work of all IMCI donors and MOH in each country; national-level indicators for regional project; cannot be collected without extraordinary resources	Consider adaptations from other LAC regional initiatives and earlier draft articulation of indicators for LACI; address in post-evaluation detailed implementation plan
3. Overemphasis on clinical training	Clinical training is the number 1 design component of WHO's IMCI; everyone started here; traditional design approach only emphasizes actual training activity, not overall situation with supporting systems	Address these system support components in preparing detailed implementation plan (in D.C.) (e.g., training follow up and ongoing supervision must be included in training budgets; incorporation of tools and the human resources required to introduce them must be included in annual IMCI plans and budgets)
4. Weak health system support (quality of services, supervision, referral, integration of IMCI indicators into health information system [HIS], monitoring and evaluation [M&E], cost analysis of drug use, cost analysis of IMCI adoption)	WHO's IMCI design was divided into three parts; because of the extreme excitement, energy, and focus put on training, the support components have almost been ignored; support components are not as visible nor as glamorous as training	
5. Existing tools are not widely used (supervision, drug management, M&E, health facility assessment, cost analysis)	Not enough holistic planning for individual MOH country-level annual plans of operations	
6. LAC Regional IMCI Initiative not receiving credit for activities supported	In-country implementers do not always know original source of funds and also have sources of other regional funds; giving credit where credit is due is a learned skill	Articulate need in concrete terms in revised roles and responsibilities of partners; reinforce need with in-country collaborators; give examples of positive recognition where it has happened (e.g., placement of agency logos in Bolivia's statistical document launched with Meta 2002 celebration)

C. ACHIEVEMENTS

All three direct partners in LACI—USAID/LAC, PAHO, and BASICS—have reason to be proud of their accomplishments. The Latin American region is serving as the test case for many aspects of IMCI and in just three years the results obtained are substantial. On a policy level, the ability to garner the political commitment at the highest levels of the MOH has been critical to the effective launching of the IMCI Initiative in Latin America. On a personal level, the dedication, enthusiasm, and optimism of MOH and NGO staff,

promoters, and mothers interviewed are proof that IMCI's success will ultimately be decided by each individual's willingness to change her/his own behavior. The evidence obtained during this evaluation is that IMCI can be successfully implemented and managed.

Additional specific achievements of the LACI are detailed below.

Advocacy

Seven out of eight countries chosen for the LACI have adopted the IMCI strategy.

Institutionalization of IMCI

In Honduras and Peru, IMCI is incorporated into the MOH's operational plans. In Bolivia, IMCI is incorporated into the MOH's Seguro Básico de Salud.

Coherence of Message

This is a key factor in any new strategy. The IMCI message has been conveyed undiluted and undistorted to different audiences at different levels.

Training Activities

Although in-country training in itself is not part of the regional initiative, its quality is related to the quality of the training manuals and the expertise of the trainers. Over 8,000 people were trained with manuals adapted from generic materials through the use of regional funds. Those interviewed had good knowledge of IMCI and an integral vision of children's health. As a result, there has been better counseling of mothers, more awareness of mothers and community members of their role in children's health, better diagnosis of pneumonia, more awareness of risk factors, and better referrals by health workers. A consequence that has not yet been documented but has been stated in several instances has been fewer children's deaths.

Adaptation and Dissemination of Tools In-country and to Other Countries

Examples include:

- Rational Pharmaceutical Management (RPM) developed by Management Sciences for Health (MSH) with BASICS and PAHO support was field tested in Bolivia and Ecuador. This tool collects cost data, assesses the role of the private sector, determines the availability of drugs at health centers, and assesses prescribing practices. It should be more widely used and is an activity that could be supported by regional funds.
- With LACI support, the Centro de Capacitación para la Lactancia Materna y Nutrición (Training Center for Breastfeeding and Nutrition—COTALMA) in Bolivia modified the community IMCI materials that were originally

developed by PAHO/UNICEF. With technical assistance from World Education, COTALMA also adapted materials for auxiliary nurses, called Complementary IMCI.

- Because of the success of the implementation of IMCI in Latin America, two PAHO representatives were invited to present their experience in an upcoming international meeting in South Africa.
- Peru and Honduras made their own shortened versions of the clinical IMCI training course (from 11 to 7 days).

Ability to Work under Adversity

Examples include the following:

- in Honduras, despite the worst hurricane in the last 25 years (Mitch), the initiative progressed;
- in Bolivia, a dedicated facilitator works on training activities on her vacation time; and
- in Peru, after work hours, an entrepreneurial young doctor conducted a thorough study of drug use in a group of clinics.

Sustainability

As of this evaluation, the LACI shows great promise for making a major contribution to the eventual sustainability of IMCI within nationwide health systems in the target countries. Currently, there are five different approaches being pursued to promote sustainability, all with initially promising results, although mostly on a limited and pilot basis to date:

- incorporation of IMCI into MOH policies,
- stimulation of donor support and funding for the expansion of IMCI,
- incorporation of health issues into activities of the education sector,
- training of community-based health promoters and mothers in IMCI messages, and
- incorporation of IMCI into the curricula of nursing and medical schools.

D. CONCLUSIONS

In summary, USAID's latest Results Review and Resource Request (R4) for USAID/LAC (March 22, 2000) states: "The IMCI initiative catalyzed acceptance of IMCI in the Americas." These 10 simple words are an incredible understatement of the enormous amount of effort and significant positive results seen so far. The progress to date is already remarkable for this stage in a multicountry effort with fairly limited funding. The recommendations presented herein are practical and viable, given the resources available, and if implemented as soon as possible, could well lead to developing some synergy between and among collaborators. It is also possible that if synergy is developed, the total achievements for LACI will exceed the sum of their individual parts.

E. RECOMMENDATIONS

The recommendations that follow are directed towards USAID/LAC and the two partners (PAHO and BASICS), as specified:

Recommendations to USAID/LAC

Funding

Continued funding should be provided to LACI, which has led to many important achievements in spite of some obstacles. Although USAID/LAC cannot accept funds from other sources, they can support the fundraising efforts of others (especially those already underway by PAHO and the ministries of health) to expand and enhance IMCI in the Americas, particularly through in-country activities.

Resources

Remaining LACI resources should be invested only in those six target countries that have so far been active participants in the initiative, unless health authorities in Guatemala and Haiti show greater interest in having the initiative implemented in their respective countries.

Steering Committee

Although considerable progress has been achieved in terms of improving the collaboration between BASICS and PAHO, the steering committee could profit from three distinct but related actions:

- having each member empowered by her/his institution with a level of decision-making authority appropriate to the critical managerial role of the steering committee;
- reaching an understanding among the partners regarding the different institutional cultures and the need to address these differences more

effectively, such as by conducting teambuilding activities with an outside facilitator; and

- redesigning the remaining annual work plans and budgets to include a clear delineation of roles and responsibilities between both implementing partners.

Indicators

Because of the regional nature of the project, indicators should be adapted to regional activities. Indicators for the overall Strategic Objective and for Intermediate Results 3 and 4 should be revised and baseline and annual data should be reported.

Recommendations to PAHO and BASICS

Compliance

PAHO and BASICS reports and work plans should be sent to USAID/LAC on a timely basis. New staff for the initiative should be approved by USAID, according to the terms of their agreements.

Appropriate Credit

In several instances, the source of financial support for LACI activities was not properly acknowledged. It is important that appropriate credit be given, according to the terms of PAHO's and BASICS' agreements with USAID.

Recommendations to All Partners (USAID, PAHO, and BASICS)

Communication among the Partners

Flow of communication between USAID/LAC and USAID Missions, as well as between PAHO and BASICS with USAID Missions, should be increased, which could lead to a more effective integration of activities at the local level.

IMCI Support Systems

Until now, the emphasis of IMCI at the country level has been on the introduction and expansion of training activities. However, this should not be done in detriment of improving other components (supervision, monitoring and evaluation, HIS, and drug management), which are equally critical. In addition, training lessons were better learned when follow-up activities were conducted to reinforce the training, showing the importance of redesigning training plans to make them complete.

Sustainability

Sustaining IMCI should be reinforced by continuing efforts at integration into nursing and medical schools' curricula, as well as by obtaining additional sources of financial support. Also important is the continuation of joint implementation activities with NGOs (such as Plan International and CARE). In addition, new programs and organizations should be contacted and made part of this initiative. Ultimately, the sustainability of the IMCI strategy will be another measure of success of this already worthwhile initiative.

Priority of Allocating Resources for In-country Activities

Given the limited resources of the LACI budget and time, the priority of the following three activities should be

- improving IMCI support systems,
- introducing and expanding the community IMCI component, and
- undertaking efforts to promote sustainability.

F. SUMMARY

The LAC Regional IMCI Initiative, at its midpoint, is at the right time to make the necessary changes for improved implementation. So far, the initiative has filled an important role in terms of supporting a composite of activities difficult to finance through other means. These activities have acted as a catalyst for a complex set of actions aimed at expanding the use of IMCI in several countries in the region. It is now critical to take advantage of the lessons from the initial period, plan and budget strategically, and move quickly to solidify what in many ways have been remarkable accomplishments.

I. INTRODUCTION

A. BACKGROUND OF THE INITIATIVE

According to statistics from the World Health Organization's (WHO) Information Kit on the Integrated Management of Childhood Illnesses (IMCI) (the information source for this section), every year approximately 12 million children in developing countries die before they reach their fifth birthday, many during the first months of life. In the region of the Americas, more than 200,000 children under 5 years of age die each year from illnesses that can be prevented or treated with relatively simple approaches. It is estimated that 70 percent of those deaths in Latin America and the Caribbean are due to acute respiratory infections (mostly pneumonia), diarrhea, measles, malaria, and malnutrition. These diseases and others, such as those caused by intestinal parasites and vaccine preventable diseases, are the principal reasons for medical consultation and hospitalization in Latin America and the Caribbean.

Projections based on the global burden of disease indicate that unless greater efforts are made to control them, these diseases will continue to be major causes of child deaths, particularly in developing countries. Frequently, children's deaths are caused by a combination of these conditions, so that most sick children come for consultation with signs and symptoms related to one or more of these diseases. In many cases, a single diagnosis may not be simple or possible. It may also be necessary to combine therapy for several conditions. An integrated approach to treating the sick child, therefore, is necessary if child health programs go beyond single diseases and intend to address children's overall health.

The IMCI Strategy

Disease-specific control programs have provided valuable lessons in the past 20 years. One of these important lessons is the need to implement strategies that promote coordination and greater integration of activities to improve the prevention and management of childhood illness. It was with these criteria in mind that WHO and the United Nations Children's Fund (UNICEF) originally developed the IMCI strategy. IMCI is an effective, low-cost strategy for improving the quality of child health at the health facility and community levels. The IMCI strategy encompasses a range of interventions for the prevention and management of major childhood illnesses, both in health facilities and in the home. It incorporates many elements of diarrheal disease and acute respiratory infections (ARI) control programs and child-related aspects of malaria control, nutrition, expanded programme on immunization (EPI), and essential drugs programs. According to WHO, implementing the strategy requires and facilitates active collaboration between these programs, and requires efforts at different levels of the health system.

Interventions

IMCI consists of a series of public health interventions, preventive measures at home and in the community, and early diagnosis and treatment. It also includes nutrition counseling, immunization, and other aspects of child health through the promotion of three main components:

- improving case management skills of health professionals through locally adapted guidelines and training activities,
- improving the health system for more effective management of childhood illness and delivery of health care, and
- improving family and community practices through education and counseling activities.

Relationship of IMCI with Other Technical Programs

Among the additional activities that IMCI promotes are immunization, nutrition, safe motherhood (antenatal, postnatal, and delivery care), and drug supply management. IMCI does not intend to replace these programs but tries to ensure that all activities are well coordinated and implemented to make IMCI more effective. In this regard, at the country level, this collaboration with other programs is fundamental for the acceptance and endorsement of IMCI clinical guidelines, as well as for their promotion and use.

Rationale for the Use of IMCI in the Americas

Although the infant mortality rate (IMR) in the Americas has declined steadily, particularly in the last few decades, there are still big differences among different countries, among population groups living in different areas in the same country, or among people with different ethnic backgrounds. The IMR in some countries of the region is still 10 times higher than in the most developed countries in the hemisphere. This difference is largely associated with high mortality from infectious and parasitic diseases. While in the developed countries, acute respiratory infections, diarrhea, and malnutrition account for only 6 percent of deaths among children under five, they account for 40–60 percent of deaths of children in the same age group in the developing countries.

Considerable resources are invested in the diagnosis and treatment of these and other child diseases in the developing countries. Some inputs, as is the case of antibiotics, are often used unnecessarily, since more than 50 percent of children given these drugs do not need them. In addition, the frequent use of antibiotics is expensive, can lead to antimicrobial resistance, can provoke drug shortages in the health services, and can prevent children who need them from receiving these drugs. The application of this strategy allows a complete assessment of a child's health status, the detection of other illnesses—even when they are not the main reason for consultation—and through better

diagnosis, savings in the use of such critical drugs as antibiotics. In addition, because of its integrated approach, which goes beyond children's health, IMCI can articulate integrated health management strategies throughout the human life cycle.

Agencies' Cooperation for the Implementation of IMCI in Latin America

To implement the strategy, the Pan American Health Organization (PAHO)/WHO, and UNICEF initially joined forces through an interagency agreement, signed in 1996, to assist national authorities in incorporating the IMCI strategy at the health services and community levels. The grant to PAHO/WHO from the United States Agency for International Development (USAID) was signed in May 1997, to assist the countries with the highest infant mortality levels in the region in the implementation of the IMCI strategy. Staff from USAID, PAHO, and the Partnership for Child Health Care, Inc. (the cooperating agency that implements the Basic Support for Institutionalizing the Child Survival Project [BASICS]), collaborated in the design of the Latin America and the Caribbean (LAC) Regional IMCI Initiative (LACI). The initiative is a \$5 million, five-year program, sponsored by the United States Agency for International Development (USAID) and implemented by PAHO and BASICS for the Bureau for Latin America and the Caribbean (LAC), Office of Regional Sustainable Development (RSD), Center for Population, Health and Nutrition (PHN). BASICS had been involved in IMCI implementation prior to this initiative and the adoption of IMCI by PAHO. See annexes A–D for the background documents of LACI (authorization, grant letter to PAHO, USAID Results Framework, and the LACI schematic design).

Broad approval for IMCI has helped mobilize several governmental and nongovernmental resources with a different degree of commitment in each country. Commitment at the national level, essential for the implementation of the strategy, began with the meeting at Santa Cruz de la Sierra (Bolivia), convened in 1996 by PAHO/Control of Diarrheal Diseases (CDD)/ARI. This meeting began by outlining the IMCI strategy and concluded with the Declaration of Santa Cruz de la Sierra, where 18 countries expressed their firm interest in making every effort to ensure that all children under five in the hemisphere have access to this strategy. The next step was the official adoption of the IMCI strategy as a basic health policy approach for securing a reduction in infant mortality.

In April 2000, USAID/LAC initiated a midterm evaluation of the LACI.

B. PURPOSES OF THE EVALUATION

As detailed in the scope of work (annex E), the purposes of this midterm evaluation are:

1. To determine if the USAID Results Framework is still valid and feasible and to recommend adjustments to the Results Framework, design, and activities, as appropriate.

2. To examine progress toward achieving the Strategic Objectives (SO) and the Intermediate Results (IRs) as planned, evaluating whether the IRs are likely to be met in a timely and effective manner. To identify specific internal/external constraints, which may limit their accomplishments or success, and to recommend adjustments based on findings and conclusions.
3. To assess how the initiative structure and design as configured are working, including both the specific technical areas and activities and the delegation of responsibilities to the two partners, as well as the working relationships and collaboration in the implementation of initiative activities. Adjustments to implementation based on findings and conclusions should be recommended.
4. To assess the administration of the initiative by USAID and the two implementing partners, including the status of coordination and communication within the organizations, specifically between headquarters and field operations and host country governments with USAID/Washington and field Missions.

C. FIELD PROCEDURES

During the first week of the evaluation, a 2-day planning meeting was held in Washington, D.C., and interviews were conducted with USAID (the Bureau for Global Programs, Field Support and Research and LAC), PAHO, and BASICS officials. Three weeks were spent in the field, one each in Honduras, Bolivia, and Peru (see annex F for the evaluation schedule and annex G for documents reviewed). Follow-up interviews (WHO, UNICEF, and the World Bank) were conducted after the first week in Honduras and after the field work was finished, in person or by telephone. Discussions were held with all key stakeholders.

During the field visits, the following individuals were interviewed in each country: the PAHO representative or acting representative and maternal and child health or IMCI responsible official at the PAHO country office; Ministry of Health (MOH) central-level and local-level staff in the localities visited; USAID Mission staff; a BASICS representative and officials; and officials from other organizations connected to this initiative (local nongovernmental organizations [NGOs]). In addition, several meetings were held during the field visits with the persons in charge of applying the strategy and interviews were held with facilitators and health workers trained in this strategy (annex H lists all persons interviewed).

The methodology applied during the evaluation was the application of both free and structured interviews. The main questions included:

- managerial structure of the initiative,
- relationships among the different initiative partners,
- technical questions,
- key achievements,

- main obstacles,
- managerial strengths and weaknesses,
- facilitating factors, and
- lessons learned.

D. EVALUATION TEAM COMPOSITION

The evaluation team was composed of two consultants. The team leader is a physician with extensive experience in the evaluation of health projects in developing countries, with good knowledge of PAHO/WHO and other United Nations agencies, and he is fluent in both English and Spanish. The other team member is an expert in nutrition with extensive experience both in program implementation and evaluation of health projects in developing countries, is fluent both in English and Spanish, and has previous experience with private voluntary organizations (PVOs), USAID, and several international organizations.

II. PROJECT DESIGN ISSUES

This section addresses aspects of conceptual design only; those aspects related to the design as it was revealed in management and implementation are discussed in sections III and IV, respectively.

A. ROLE OF THE IMCI REGIONAL INITIATIVE

By definition, a regional initiative is designed to conduct regional activities. The LAC Regional IMCI Initiative was designed to help make IMCI well known in Latin America. Two partners (PAHO and BASICS) were chosen to implement the initiative, with special focus on eight target countries. The budget, \$5 million over five years, was not designed to sustain long-term activities of any given partner in any given country. Rather, the budget was developed for selected activities that would act as a catalyst for IMCI in the region.

From a management point of view, a regional initiative is different from a typical project with its own staff and budget. While the LACI has a central manager, the cognizant technical officer (CTO) in USAID/LAC, all other professionals working on this project report to supervisors in other management structures in other organizations. Thus, the initiative is built on the assumption that the key stakeholders are able to work effectively as team members even though their compliance is not required through direct supervisory lines. Discussion of the findings regarding the management of the LACI is found in section III.

In addition, given no direct management authority over the partners and a budget which was designed to stimulate, not sustain, in-country activities, the LACI took on considerable risks that it could effect significant changes in the region, and especially the eight target countries in the time frame allowed. In short, the initiative took on the role of a catalyst for introducing IMCI in Latin America. The key features of a catalyst in this program setting are:

It is a small amount of funds, effort, and input; it sets off a reaction which would not otherwise be happening; the substance loses its identity in the reaction; the end product is considerably different from any of the original separate ingredients (contributions by USAID, PAHO, BASICS, and other collaborators); and the catalyst cannot be recovered once the reaction has taken place.

The way in which the LAC Regional IMCI Initiative has functioned as a catalyst, joining efforts of other agencies and governments, and the results produced are described in subsequent chapters of this report.

B. OVERALL PROJECT DESIGN COMPONENTS

The LACI is implemented through two partners: PAHO, through a grant, and BASICS, through field support to the contract that BASICS has with USAID/G/PHN. Compared with other USAID/LAC regional initiatives, the IMCI effort has fewer partners and one of them, PAHO, is also a partner in other initiatives. Nevertheless, the findings of this evaluation suggest that the absolute number of partners may not be as important to collaborative harmony as the willingness to collaborate and the teambuilding skills (e.g., effective two-way communication, compromising, giving and receiving constructive criticism, planning, mutual accountability) of the specific partners.

The original design contemplated change throughout the region and targets eight countries: Guatemala, Haiti, El Salvador, Nicaragua, Honduras, Ecuador, Bolivia, and Peru. However, since the partners are also involved in other IMCI commitments (PAHO in other countries throughout the Caribbean, Central and South America, and BASICS in other countries in Africa and Asia), trying to focus the LACI on these eight specific countries creates difficulties in setting priorities for one's efforts. One way these difficulties are expressed is in the steering committee, as described in section III.

C. APPROPRIATENESS OF THE USAID RESULTS FRAMEWORK

The original schematic design of the LACI (see annex D) shows three phases of the initiative: design, implementation, and monitoring and evaluation (M&E). Although the presentation of these phases as separate components may be useful as an organizational aid, the separation of M&E as a distinct phase can lead to difficulty if viewed as chronologically distinct—by weeks, months, or even years—from implementation. Plans for M&E, including indicators, frequency of collection and analysis, the baseline survey, and resources for M&E, should all be determined before the first day of implementation and then incorporated as an ongoing implementation activity. Further discussion of the role of M&E as a support function in IR 3—building country capacity to implement IMCI—is discussed in section IV.

Strategic Objective (SO) and SO Indicators

The Strategic Objective for the LACI is, “More effective delivery of child health services in response to CDD, ARI, and malnutrition.”

The SO indicators are the number of target countries with

1. 90 percent of facilities in pilot districts delivering IMCI services, and
2. 10 percent of facilities delivering IMCI services.

The original SO indicator 1 was: “Number of target countries with 100 percent of facilities in pilot districts delivering IMCI services.”

These two indicators represent appropriate targets for IMCI in general, for example, for all donors and the MOH to work on in any given country. However, for just one donor, they are inappropriate because they reflect the efforts of the entire country (or region or district) and therefore there is little possibility of connecting one donor's inputs to the outcomes (referred to as "plausible attribution" by USAID). In addition, it is too difficult for PAHO and BASICS to report on these indicators because they are out of the control of the supervision scope of the two partners. Finally, even if the participating countries had the means to and agreed to help provide the data necessary to calculate these indicators, it would be too expensive an undertaking—relative to the total budget of the LACI—to gather the data in a comprehensive, timely, and accurate manner.

These indicators, or other related ones developed to suit the unique conditions of each country, are more appropriate for each country to collect, using resources available from all partners contributing to IMCI. In addition, these indicators would need to be used in a timed fashion, such that each country would set up appropriate annual goals in their quest for fulfilling the indicators.

The LACI partners are in agreement over their concern about the indicators and their desire for changes to be made. Even though discussions on this issue have already taken place with USAID/LAC, the parties involved are still in disagreement about the viability of these indicators. Since useful data are not being collected to calculate them, all parties need to return to discussing the issue. One potentially rich source of ideas for revised indicators comes from earlier discussions among the partners where indicators were developed but then not used.

Other USAID/LAC regional initiatives can provide examples of potential indicators that could be adapted for the LACI. For example, the following two indicators are taken from the latest USAID/LAC Results Review and Resource Request (R4) report (March 22, 2000) and seem useful as points of departure for IMCI regional indicators:

1. "For the third year running, 100 percent of the methodologies and tools introduced by the health sector reform initiative were used by 50 percent of the countries where introduced." (Key Results, p. 25) This indicator could be adapted for IMCI.
2. "Target countries with reform processes that substantially integrate lessons learned from this initiative (methods and tools, information, monitoring and exchanges)." (Health Sector Reform section)

The LAC Regional IMCI Initiative can play an important role in advising the participating countries about potentially useful indicators they can adopt for monitoring the implementation and results of IMCI. However, the partners in the regional initiative itself must be in agreement about their own indicators first. (See the recommendations for additional details regarding the suggested process for developing new indicators.)

Intermediate Results (IRs)

The four IRs and their respective indicators are listed below.

IR 1: Country leaders have information for IMCI adoption.

- Indicator 1: Number of target countries where country Ministry of Health leaders have adequate information regarding IMCI
- Indicator 2: Number of target countries with official decision to adopt IMCI

IR 2: Country plans and strategies in place for introduction and implementation of IMCI

- Indicator: Number of target countries with national operational plans in place

The original indicator for IR 2 was: “Target countries with IMCI plans and strategies adopted including identification of resource requirements.”

IRs 1 and 2 and their indicators are adequate as written and no revisions are recommended.

IR 3: Improved country capacity to implement IMCI

- Indicator 1: Number of target countries with more than 10 percent of ambulatory health facilities in designated areas which have IMCI norms, health service providers trained in IMCI, and IMCI essential drugs available.

The original Indicator 1 included “... IMCI essential drugs available at least 75 percent of the time; and district plans that include IMCI at this level.”

- Indicator 2: Number of target countries with 80 percent of designated districts with plans for IMCI implementation developed.

The original Indicator 2 included “... countries with 100 percent of pilot districts when have: IMCI norms available; service providers trained in IMCI; IMCI essential drugs available at least 75 percent of the time; and district plans that include IMCI at this level.”

Comments and recommendations regarding the viability of indicators 1 and 2 for IR 3 are exactly the same as those made above for the SO indicators, given the similarity of these two sets of indicators.

IR 4: Monitoring and evaluation used to adjust IMCI program plans

- Indicator: Number of target countries that have incorporated monitoring and evaluation findings into annual IMCI district plans.

The original indicator for IR 4 was “...countries with IMCI annual plans that reflect findings from monitoring and evaluation.”

Dedicating an IR specifically to monitoring and evaluation functions is commendable. However, as currently written, this indicator can be too easily checked off when “completed” even just once, in one district, in one year. In reality, this indicator needs to better capture the evolving (and, it is hoped, ever improving) process of monitoring and evaluation as it is introduced, used, and integrated into the fabric of a district’s annual operating health plan.

In general, the four IRs above read more like steps in implementation as opposed to reflections of overall results and accomplishments necessary to lead to IMCI being used in the region. The indicators for IRs 1, 2, and 4 do not necessarily reflect the quality, extent (coverage), or results of the implementation of activities supported by LACI. In contrast, the indicators for IR 3 go well beyond the scope of LACI.

The proposal (January 7, 1997, p. 3) includes in the narrative a number of expected conditions that seem to reflect what the partners expect as a result of implementing the LACI. (The words in italics are examples of the “promises” of IMCI and are potentially useful characteristics of positive IMCI results that could be the points of departure for developing revised indicators.)

- “...integrated management can mean *greater efficiency* in training, supervision, developing policies and norms, and monitoring and evaluation from the community level to the health care facility...”
- “...over time, *resources required may be reduced*...”
- “...IMCI approach can *avoid the duplication* of efforts...in training and implementing parallel vertical control programs in acute respiratory infections (ARI), control of diarrheal diseases (CDD), nutrition and vector borne disease...”
- “...positive *complementarity* of proposed activities with country-level child health care priorities...”
- “...*strengthening regional and subregional technical cooperation* in child survival among the participating countries...”

III. MANAGEMENT AND ADMINISTRATION FINDINGS

A. MANAGEMENT STRUCTURE

The LAC Regional IMCI Initiative is implemented through two partners: PAHO and BASICS. The original idea was that each partner would bring its own unique and yet complementary assets to the initiative. PAHO would bring its role as the natural counterpart for the ministries of health in the region, its technical expertise, its previous experience with different components that comprise IMCI (e.g., acute respiratory infections, diarrheal diseases), its presence in every country, and its long-term experience working with different partners on regional health initiatives. BASICS would bring its technical expertise, its experience in IMCI in other regions, particularly Africa, and its prior experience as a USAID contractor, which facilitates communications with USAID Missions. However, BASICS' contribution is conditioned by USAID Missions' interest that Global Bureau projects work in close partnership with their in-country bilateral activities and their willingness to support national IMCI implementation. Also, since BASICS is a contractor of the Global Bureau, the LAC IMCI Regional Initiative requires considerable collaboration between USAID/LAC and the Global Bureau.

There is presently a steering committee made up of representatives of USAID/LAC, the Office of Health and Nutrition (USAID/G/PHN/HN), PAHO, and BASICS. Currently, this group meets regularly for information exchange, joint work planning, and progress reports. Although the local USAID Missions initially participated in the initiative's design, they are not active partners in its day-to-day management.

Strengths of the Management Structure

Decentralization of decision-making (through PAHO and BASICS and then to their respective country offices) allows for innovation and responsiveness to local conditions.

Flexibility offered by USAID/LAC in the use of regional funds within the parameters of the proposal allows funding of regional activities not funded normally through other agencies or governments.

Weaknesses of the Management Structure

Insufficient Decision-making Power

As presently organized, the steering committee does not have sufficient decision-making power. For example, the PAHO representative at the steering committee is not authorized to make management decisions, thus diminishing the effectiveness of the steering committee.

Legal Agreements with USAID/LAC's Two Partners

The legal agreement with BASICS is a contract and the agreement with PAHO is a grant. The degree of USAID's substantial involvement is greater in the former than in the latter, thus setting the stage for disagreements and differing expectations. Some expected deliverables planned in the original proposal have not been met according to schedule; thus, new terms have to be negotiated with specific consequences for noncompliance.

Definition of Roles and Responsibilities between PAHO and BASICS

From the very beginning, roles and responsibilities were not clearly delineated, which led to frequent misunderstandings. The proposal states, "In terms of the activities envisioned under this proposal, PAHO and BASICS will share implementation responsibility, according to each partner's technical and organizational strengths" (p. 7). Even though the proposal was prepared jointly by PAHO and BASICS, it naturally did not include the specificity in practical terms regarding day-to-day roles and responsibilities. Unfortunately, subsequent documents, such as the annual work plans, lacked clear definition on this point.

Concept of Lead Partner

The original proposal stated, "Because of its permanent intergovernmental nature in the region, PAHO will assume the overall coordinating role for this LACI." (p. 7) Subsequently, a decision was made whereby PAHO and BASICS took the lead partner role in four different countries each. For various reasons, this concept did not work out in practice; however, the need remains for one partner in each country to be the country-level coordinator for the LAC Regional IMCI Initiative. Since neither partner is now designated as the lead partner, coordination of their joint activities is left to chance. While in Honduras this situation has hampered progress, in Bolivia it has not disrupted the long-term effective working relationship between PAHO and BASICS. In Peru, there is no BASICS presence. The designation of a lead partner in each country should be based on criteria developed by the steering committee and need not result in an even division between the partners.

Transition of BASICS I to BASICS II

BASICS I came to an end near the end of the second year of the regional initiative. This prevented long-term planning from BASICS for the five-year initiative. In addition, the transition from BASICS I to BASICS II was unusually protracted, thus creating a gap in the field while usurping management attention among the stakeholders in Washington.

Multiplicity and Parallelism of Management Structures

Almost all persons involved in the LAC IMCI Regional Initiative report to different supervisors within different institutional structures. This inhibits the implementation of decisions. Furthermore, for these same persons, the LAC Regional Initiative is usually

less than 50 percent of their total scope of responsibilities, thus also limiting their engagement in the process. Although these LACI management features are an inherent part of the initiative and probably cannot be modified, they need to be considered as plans and expectations for the remainder of the initiative are developed.

Lack of Communication

The USAID/LAC is being perceived as “overworked and understaffed” and therefore unable to communicate about IMCI as well as it might otherwise. This situation is manifested in little direct communication between USAID/LAC and the participating Missions.

B. IN-COUNTRY COORDINATION OF ACTIVITIES

Honduras

The coordination of activities at the country level had different characteristics in the countries visited. In Honduras, there is a need for strong leadership, particularly from the Secretary of Health. In addition, the PAHO representative has recently arrived in Honduras and is only now in a situation of closely following project activities. Presently, there is not a functioning interagency group in Honduras. However, representatives of the Secretary of Health, bilateral agencies, and NGOs have formed a group called Comunicación en Salud Infantil (COMSAIN), one of whose main functions is the elaboration and unification of educational materials related to children’s health. With strong leadership from the Secretary of Health, such a group could become an effective coordinator of IMCI activities in the country. Although there is a good personal relationship between the persons at BASICS and the PAHO staff responsible for IMCI, there is no joint planning or monitoring of activities related to IMCI between them. Joint planning, if done effectively, can increase the probability for more efficient use of resources, creative problem solving, and ultimately, synergy in programming.

CARE coordinates its activities with the Secretary of Health, which trains CARE personnel. UNICEF has financed several training activities, and has participated in the adaptation of educational materials, particularly those related to the area of communication in child health. Under consideration is an American Red Cross grant to PAHO for US \$6.7 million for IMCI training activities in several countries, including Honduras.

Bolivia

In Bolivia, there is a very effective interagency committee devoted to children’s health care issues, which existed before the LACI. The activities of this committee comprise review and support of the MOH’s annual operating plan; exchange of information; sharing of experiences in monitoring and evaluation; provision of technical assistance and financial contributions; and review of documents. The clear and effective leadership of the MOH is a critical factor. NGOs can relate to this committee either directly or

through their membership in Programa de Coordinación en Salud Integral (PROCOSI), an NGO network. There is strong leadership from the Ministry of Health and an excellent working relationship between the PAHO and BASICS staff in charge of the implementation of IMCI at the country level, as well as between them and the USAID country office. All of these conditions help foster a very fertile environment in-country for making optimum use of the inputs provided through various LACI activities and channels.

In what could be a useful contribution to LACI efforts, the USAID country office, with the collaboration of the Global Bureau, has developed an IMCI interactive training course in Spanish, which was first tried in Uganda in its English version. That course was a useful tool for IMCI and has been approved both by WHO and Bolivia's Ministry of Health. Through the initiative, this course could be introduced in the other participating countries.

Because of administrative problems, UNICEF Bolivia is not closely involved in the implementation of IMCI in the country. UNICEF has financed some training activities and the production of educational materials and has played a critical role in the incorporation of the IMCI strategy in the Seguro Básico de Salud, a health insurance system for children and pregnant women. This has helped institutionalize IMCI and has greatly contributed to the rapid expansion of the strategy at the country level. In addition, UNICEF has financed the inclusion of IMCI in the curriculum at the medical school of University of San Andrés in La Paz.

Peru

In Peru, IMCI activities are coordinated by the Ministry of Health with the cooperation of PAHO. There is an effective interagency committee convened by PAHO's representative in the country. At the Ministry of Health, there is an IMCI national coordinating committee (Comité Coordinador Nacional Atención Integrada a las Enfermedades Prevalentes de la Infancia [AIEPI, or IMCI]–Ministerio de Salud [MINSA, or MOH]) that was established in 1997 and which coordinates IMCI activities in the country.

The local USAID office is directly supporting IMCI, mainly through some training activities funded through the bilateral Proyecto 2000. Funds from this project are used for maternal and child health training activities in 12 subregions in the country, for training community health workers, and for a project on the rational use of medicines (uso racional de medicamentos). LACI funds for IMCI advocacy, materials adaptation, and limited implementation activities are channeled through USAID's grant to PAHO, as there is no BASICS presence in Peru. There is no joint planning of activities or other collaboration between USAID/LAC and the local USAID office for the implementation of IMCI in the country. There was limited support of USAID/Peru to BASICS in 1998 to organize IMCI training courses. The World Bank is providing financial support for strengthening the health infrastructure in several provinces, and Plan International is conducting an intensive set of training activities in community IMCI as part of pilot projects in Piura and Sullana.

C. STAFFING

PAHO

At PAHO headquarters, the AIEPI (IMCI) technical and management unit comprises six staff members, all of whom have extensive experience in international public health and interagency technical cooperation in Latin America. There is a regional advisor for IMCI who is responsible for the coordination and supervision of technical and administrative issues relevant to IMCI within PAHO, including management and coordination of the LAC Regional IMCI Initiative. The regional technical officer is responsible for supporting IMCI planning, monitoring, and evaluation; he regularly attends the steering committee meetings in Washington, D.C. Both of these positions are funded 100 percent by PAHO as a counterpart contribution to the USAID grant. There also is a regional IMCI specialist in charge of administrative issues, special presentations, documentation review, proposal writing, and training needed in the LAC Region. Funded from PAHO's own budget as a counterpart to the USAID grant, there are six PAHO national IMCI consultants responsible for specific IMCI activities (to which they dedicate approximately 50 percent of their time) in Honduras, Bolivia, Peru, Ecuador, Haiti, and El Salvador. In the other target countries, PAHO staff carries out IMCI duties. In addition, PAHO has been providing additional technical support to the countries by sending consultants on an ad hoc basis. Also paid by the Initiative are three short-term consultants: a subregional consultant and two consultants who serve as administrative staff.

BASICS

At the headquarters level, BASICS' senior management group delegates program management responsibility to regional and country clusters composed of operations and technical division staff, as well as to technical working groups, which coordinate their actions with USAID's Global Bureau. During BASICS I, there was a LAC operations officer in charge of overall planning, management, and coordination with PAHO and USAID's Global and LAC Bureaus, and a senior technical officer in charge of managing all technical aspects of IMCI implementation, in close coordination with PAHO, particularly at the beginning of the project. Both of these positions were part time to this initiative. The operations officer is not connected to this initiative any longer, and the senior technical officer is now in charge of IMCI implementation at the global level. For BASICS II, there is a full-time technical officer who has been closely following the implementation of regional and subregional clinical training courses and other technical workshops in coordination with his PAHO counterpart. They are both members of the initiative steering committee. An operations coordinator is in charge of tracking work plans with USAID's Global Bureau and preparing technical directives and clearance requests.

Honduras

In Honduras, at the Secretary of Health, IMCI activities are coordinated by the chief of the Department of Maternal and Child Health and by the officer in charge of AIEPI, who is directly responsible for IMCI activities. The PAHO officer presently in charge of the initiative has only recently been given this responsibility and cannot devote all his time to it since he has other responsibilities. The BASICS representative is in charge of following the implementation of the initiative in the country.

Bolivia

In Bolivia, the chief of the National Program for People's Care (Programa Nacional de Atención a las Personas) of the Ministry of Health is an effective coordinator of IMCI activities in the country. Because of his previous role as president of the Bolivian Pediatrics Society, he has been able to quickly move the strategy forward. He coordinates an active interagency committee that includes bilateral agencies and NGOs working in the country. A consultant in child and perinatal health from PAHO is in charge of IMCI activities, which are not her sole responsibility. On the BASICS side, both the BASICS representative in the country and a technical officer are in charge of the implementation of the initiative.

Peru

In Peru, the MOH is in charge of implementing the IMCI strategy in the country. At the Ministry of Health, there is a Comisión Nacional Coordinadora (National Coordinating Commission), with representatives from the MOH, PAHO, UNICEF, USAID, and the MOH program directors. This group is responsible for the preparation of operational plans and monitoring activities. In Peru, the World Bank is supporting a health sector reform project that will lead to the integration of several programs. At the ministry level, however, there are still 21 different vertical programs. The infecciones respiratorias agudas (acute respiratory infections [ARI]) program coordinates the institutional IMCI and the enfermedades diarreicas agudas (control of diarrheal diseases [CDD]) program coordinates the community IMCI activities. Both types of activities are under the supervision of the executive director of Women and Children's Health Programs and the Programa Ampliado de Inmunizaciones (Expanded programme on immunization [EPI]). Because there is no BASICS counterpart in the country, PAHO is the main technical support for the Ministry of Health, a function that is effectively carried out by the officer in charge of following AIEPI for PAHO.

D. INFORMATION SHARING AMONG IMCI COUNTRIES

Information sharing about IMCI activities in the countries involved normally occurs through two mechanisms. One mechanism is yearly meetings for PAHO personnel with the participation of technical officers involved in the initiative, where progress and problems that hinder the implementation of IMCI in the region are discussed. During these meetings, which have a strong element of self-criticism, PAHO's regional activities and plans are discussed and organized to make them coincide with the plans of the MOH, so as to make these plans both possible and sustainable. In addition, two yearly meetings

(Evaluation and Planning Meetings for the USAID/LAC-PAHO-BASICS Initiative) took place, one in Quito, in 1998, and one in El Salvador, in 1999, with the next one planned to take place this year in Honduras. During these meetings, progress in IMCI implementation at the country level is discussed and several workshops are conducted, covering such topics as how to expand activities without losing quality, how to improve monitoring and evaluation, coordination, and mobilization of resources to support IMCI strategy implementation, IMCI, and nutrition. These meetings are attended by officers from financing and implementing organizations, as well as from the Ministries of Health and NGOs focused on by the initiative.

E. CONCLUSION

As presently organized, the initiative does not have a strong central managerial structure, a role that could be fulfilled by the steering committee. One of the functions of this committee should be the formulation of detailed implementation plans, which would clearly define the roles of both PAHO and BASICS. One of these responsibilities, already stated in the original proposal, was for PAHO to have overall coordination responsibility, a role which changed with the decision to give both partners a leading role in each of four countries. When that plan did not work out, no replacement plan was set in place, with the result that the coordination of activities between both partners in each country is practically left to chance. A stronger steering committee could fill the vacuum in the presently weak managerial structure of this initiative and become a key factor for improving implementation.

IV. IMPLEMENTATION FINDINGS

Through its contractual agreements with PAHO and BASICS, USAID/LAC is funding a series of activities in the form of the LAC Regional IMCI Initiative. The actual channels for funding these activities are complex as they involve two implementing partners who execute LACI activities in Washington, D.C., and in specific countries which serve as the host for a regional or subregional event or which are the recipients of funding for a specific in-country activity (e.g., a national IMCI evaluation). In the three countries visited, the evaluation team found that it was often not possible for the PAHO, BASICS, or MOH interviewees to easily identify the exact source(s) (or breakdown among sources) of funding for any given activity without detailed research into the financial records.

For example, PAHO has a variety of funding sources to support its IMCI activities in the region, of which LACI is one. PAHO maintains LACI funds to be expended in Washington, D.C., on behalf of the eight LACI target countries and also remits funds to these countries for LACI-sponsored activities. Each country also has PAHO funds from other sources (via Washington, D.C.) to support the country program which includes IMCI. Thus, any given activity that focuses on IMCI could have a variety of logical funding sources. The situation with USAID is similar in that BASICS in-country has several potential funding sources, inter alia, bilateral funds from the local USAID country Mission, country-specific funds managed by BASICS in Washington, and core funds from BASICS. Finally, given that IMCI is supported by donors other than USAID/LAC and PAHO, any given in-country activity that is contemplated in the LACI annual work plan and budget could eventually be cofunded by other donors.

To the extent possible, the evaluation team tried to identify the source(s) of funds for the activities discussed in this report. (In this regard, any error of attribution is the responsibility of the evaluation team.) The fact that it was difficult to trace the path of LACI funds directly as various IMCI activities were explored in the three countries visited does not suggest that these funds have not and are not being appropriately programmed and recorded.

A. STATUS OF ACTIVITIES TO DATE

Strategic Objective: More Effective Delivery of Child Health Services in Response to CDD, ARI, and Malnutrition

Originally, PAHO developed an indicator-based worksheet which was sent to the countries to try and collect information on the SO and IR indicators. This activity included working collaboratively with WHO and BASICS to define the indicators and develop the format for PAHO to analyze the results. However, the indicators for the SO

and IRs 3 and 4 in use at the time of the evaluation were not functioning for the overall monitoring of LACI.

Although neither PAHO nor BASICS is presently collecting information on the two SO indicators, based on data gathered and interviews with health officials both at the central (MOH) and peripheral levels (hospitals, clinics, and health centers), significant progress has been achieved towards this goal.

Intermediate Results

IR 1: Country Leaders have Information for IMCI Adoption

By 1999, all eight countries included in the LACI had information about this initiative.

IR 2: Country Plans and Strategies in Place for Introduction and Implementation of IMCI Services

Progress in Haiti has been exceedingly slow. As of the time of the evaluation, only Guatemala was still reluctant to implement IMCI. A change in government is most likely necessary before the Guatemalan MOH would be willing to consider IMCI.

IR 3: Improved Country Capacity to Implement IMCI

The two indicators for this IR did not seem to be reported on (as of 1999) because they are country-level indicators requiring detailed information not available yet in the participating countries visited.

Training to Date

According to PAHO (1999 Report to USAID/LAC), the following results have been obtained regarding training activities that have used manuals and other materials developed and/or adapted through LACI-funded activities:

- **Number of facilitators:** A critical mass has been established for replicating IMCI at the district and local levels.
- **Number of courses:** Over 200 national and operational IMCI clinical courses have been conducted; in addition, PAHO has developed three community-level training courses.
- **Number of people trained:** Over 8,000 health workers have been trained in the IMCI clinical course in the 8 Latin American countries involved in the initiative.

Training Effectiveness

Although the LACI provided funds directly for developing the national training teams, information was obtained regarding the subsequent ripple effect that these national teams have had on training effectiveness in the three countries visited. Effective training depends on several factors, including quality of the trainers; adequacy of the training materials to the trainees' levels of understanding; appropriate length of the training event; appropriate selection of trainees with similar levels of training needs (i.e., not mixing auxiliary nurses, licensed nurses, and doctors); appropriate number of trainees; adequate ratio of facilitators to trainees; and timely and high-quality follow up. Among these factors, one of the most consistent weaknesses reported was the lack of timely follow up to the IMCI institutional training. In addition, in those facilities where the nurses are trained and the doctors who supervise them are not, IMCI cannot be effectively implemented.

Presently, the number of facilitators available for training activities cannot meet the demand as training spreads geographically and at different levels of health personnel (i.e., institutional—licensed nurses and doctors, auxiliary nurses, and community health workers). Although a systematic evaluation was not conducted of the IMCI training for health professionals (licensed nurses and doctors), auxiliary nurses, and community promoters, based on the interviews conducted with different levels of health workers, it appears that the quality of training has been adequate. However, in the case of Bolivia, the MOH decision to shorten the IMCI institutional course from 11 days to 5 has serious implications; the decision has been met with almost universal criticism, principally because of the negative effect on the quality of the training (and hence the wise use of resources for that training).

In Bolivia, due to the low literacy level of the auxiliary nurses, a complementary course (with funding from BASICS) was developed by the Centro de Capacitación para la Lactancia Materna y Nutrición (Training Center for Breastfeeding and Nutrition [COTALMA]). The course has less technical content and more graphic materials than the standard IMCI course to facilitate comprehension. Technical assistance from World Education helped the facilitators develop nonformal adult education methods for use with the materials adapted for this group of trainees.

Overemphasis on Clinical Training and Underemphasis on Health Systems Support Components

Although IR 2 contemplates that plans and strategies will be in place for IMCI implementation, it appears that the clinical training component has received the vast majority of attention. In the three countries visited, IMCI training activities are expanding too fast, to the detriment of other system components. Reasons for this imbalance include

- greater donor interest in clinical training to introduce a new technique (IMCI) than in the less attractive and more complex systems needed to support the trainees once they return to their jobs,

- MOH vulnerability to accepting donor funds for training without challenging the conditions,
- country IMCI leaders did not develop a detailed series of preconditions for initiating clinical training, and
- emphasis by WHO to implement clinical training, as the manuals for this component were the first tools developed.

This major emphasis on training (initially clinical and now community IMCI) has prevented significant attention from being given to the supporting components. IMCI's second component comprises quality of services, supervision, and integration of IMCI indicators into HIS; monitoring and evaluation; management and cost analysis of IMCI drugs; health facility assessment; and overall cost analysis of adopting IMCI. If this trend continues, the potential for systematic monitoring and evaluation will be seriously impaired and thus the ability to realize and document IMCI's impact on reducing costs, morbidity, and mortality.

In most regions visited, the specific health system component that interviewees were concerned about was supervision. Results from a study in Kenya showed that new knowledge about IMCI, when not reinforced, has a tendency to be lost within one year. This finding underlines the need for regular supervision, an activity which is not being carried out in the three countries visited during this evaluation (and which was never expected to be funded by LACI). Although lack of financial resources was often cited as a major impediment to undertaking supervision, in the long run, it is more cost-effective to finance supervision than to risk investing major resources in training without addressing this critical component.

The LACI partners—PAHO and especially BASICS—have helped develop a long list of useful tools for IMCI, including many of the training materials and tools for addressing the systems support functions, such as supervision. In sum, these latter tools are underused in the countries visited and may be throughout the region if the Rational Pharmaceutical Management (RPM) experience is indicative of a wider phenomenon (see discussion in the section on development and use of tools).

IR 4: Monitoring and Evaluation is Used To Adjust IMCI Program Plans

In Honduras, a baseline study was conducted which addressed the availability of human resources, drugs, and quality of care. The next step is to refine the instrument and apply it in regions II and III in that country. In May 2000, BASICS plans to develop an instrument for evaluating IMCI in the countries implementing the initiative. To the extent that supervision is taking place, there may well be adjustments made on a case-by-case and visit-by-visit basis. At the community level, BASICS is supporting a multiyear study to assess the ultimate changes in nutritional status of children in the areas where *atención integral al niño* (integrated attention to the child [AIN]) has been introduced.

In Bolivia, there was a formal baseline study of the three early intervention areas (May–July 1998) and a subsequent evaluation in April 1999. This was the first IMCI evaluation of its type to take place in the world. According to the coordinator of the training center at the Children’s Hospital in Santa Cruz, the evaluation findings were used to

- modify those training aspects that were found to be weak, such as the proper diagnosis and treatment of pneumonia and anemia, counseling to mothers, and immunization practices; and
- improve the inputs for IMCI through Seguro Básico de Salud, such as the provision of drugs to health facilities.

In Peru, an IMCI evaluation funded by LACI was carried out in 1999. Although substantial data have been collected, the results are still being analyzed.

Based on the three countries visited, the following items still need improvement:

- Many districts still have irregular supplies of the key diagnostic IMCI form used when interviewing the mother and examining the child, and
- There is a lack of specific training follow up (within several weeks and then after approximately 6 months) and no systematic supervision of health personnel trained in IMCI to reinforce new learning, resolve problems, and share experiences.

Both of these aspects could be addressed at regional meetings to make national officials aware of their importance for the best implementation of the initiative.

B. DEVELOPMENT AND USE OF TOOLS

Development of Tools

In Washington, BASICS has developed a set of tools for IMCI; PAHO has translated and developed many WHO materials for IMCI, for example, a set of materials geared to the training of the *agentes comunitarios de salud* (community health workers) that has served as a basis for country adaptation.

An RPM tool was developed by Management Sciences for Health and financed by BASICS, with the collaboration of PAHO, which collects cost data, assesses the role of the private sector, determines availability of drugs at health centers, and looks at prescribing practices. This tool is now being used in Africa and has been field tested in Bolivia and Ecuador. The tool has raised awareness about the drug situation, has created the conditions for fluid dialogue between IMCI staff and the central drug officials in the countries, has provided information on costs so as to quantify savings through IMCI implementation, and has created baseline information to measure improvement in drug

use. It needs additional funding, however, for effective advocacy to promote wide application.

To support the community AIN in Honduras, BASICS has

- developed a set of counseling sheets (láminas de consejería) for use when talking to mothers, as well as a facilitator's guide and a manual for monitoring AIN;
- adapted the IMCI flow chart to include supplementing all preschool children with iron and vitamin A;
- incorporated criteria for the classification of dengue fever; and
- defined criteria for the proper diagnosis of streptococcal laryngitis so as to avoid the excessive use of antibiotics.

An evaluation instrument for IMCI is to be developed in May 2000 for use at the regional level.

A set of 10 materials was translated and adapted for Bolivia and was supported by PAHO, BASICS, MOH, Community and Child Health (CCH), the Bolivian Pediatrics Society, and UNICEF. Also in Bolivia, AIEPI comunitario materials are in the final stages of development by COTALMA. An instrument for follow up (seguimiento) of the trainees has also been developed.

Use of Tools

In Bolivia, in order to expand the training in AIEPI complementario, the MOH is developing intermediary training centers in rural areas to facilitate access of auxiliary nurses to the training process. The first major pilot test of the community materials adapted by COTALMA is scheduled for May 2000. BASICS will be supporting PLAN International's work with community health workers in the Aroma District of the Altiplano.

The only two countries to use the RPM tool to any significant degree are Bolivia and Ecuador. In Bolivia, it has been incorporated into the MOH's Seguro Básico de Salud, which may lead to the sustainability of this critical IMCI component. The cost of introducing this tool may be the major impediment to widespread use.

C. INTERAGENCY COLLABORATION

Ever since IMCI was developed by WHO and UNICEF in the early 1980's, the strategy has been adopted and supported by a growing number of public and private institutions: multilateral (UNICEF and the World Bank), bilateral (governments of Canada, Germany, the Netherlands, Japan, Spain, and the United States), national (MOHs, pediatric

societies, and nursing and medical schools), NGOs, and even individual doctors in their private practices.

Since 1998, UNICEF has been coordinating the worldwide IMCI Interagency Group, stressing the community aspects of IMCI, and has helped in the development of several training and health facility assessment tools. UNICEF has also been instrumental in the incorporation of IMCI into de Seguro Básico de Salud in Bolivia.

Interagency collaboration can be manifested in at least three different, simultaneous, and complementary ways: by the agencies and governments collaborating through financial contributions (World Bank), by providing technical assistance (BASICS and PAHO), and by implementing various levels of operations (NGOs and the MOH).

D. COMMUNITY PARTICIPATION

WHO's original generic IMCI materials specify three main building blocks of IMCI: trained human resources, systems support, and the community role. To date, the emphasis has been on the first two components, with heavy weighting on training. Traditionally, the major stakeholders in community activities have been the NGOs and those institutions that finance them (e.g., UNICEF, USAID). While UNICEF was initially expected to take a major worldwide role in the development of the community aspect of IMCI, its emphasis to date has been in five countries in Africa and one (Ecuador) in Latin America. UNICEF is presently developing a district-based communications strategy to actively involve families and communities in children's health. Part of this strategy will be a manual that can be used throughout Latin America. Aspects of community participation in the three countries visited are described below.

Honduras

Even before IMCI began in Honduras, the health authorities in the country had already been working in developing and implementing a strategy geared to children under 5, and based in the active participation of the community. The point of entrance for children's care under this strategy—AIN—is the growth and development of the child. USAID/Honduras and BASICS were and continue to be major supporters of this approach.

In contrast, PAHO's support for the institutional component of IMCI naturally led to the development of an approach to and materials supporting a different community-based component. The emphasis of this approach is more focused on identifying and treating sick children than on promoting health and preventing disease. Thus, these two differing approaches have stimulated significant debate on their relative merits and weaknesses. As a result, overall progress in IMCI has slowed down and probably now will be able to regain its initial momentum following the recent Secretary of Health decision to apply institutional IMCI at the health services' level and AIN Comunitario at the community level.

There is increased interest in developing the aspects of community IMCI that focus on promoting a child's health on a day-to-day basis versus intervening only when the child is sick. In this regard, the community health promoters and mothers are not the only community-based individuals who can play a role in developing these aspects. For example, members of the extended family, traditional midwives, schoolteachers, and religious leaders are potentially important allies and thus potential trainees in community IMCI.

Bolivia

In Bolivia, the major stakeholders in IMCI all agree on the need to develop and implement the community-based component. The materials supporting this intervention (facilitator's guide, training manual, hand-held flip chart, the modified IMCI protocol, and the technical manual) are aimed at the community health workers (ACSh) and were pilot tested in Calamarca in March 2000. They have been revised and are now in the final stages of production. The next step is for BASICS and PAHO to support PLAN International's introduction of these materials with their ACSs in selected areas of the Altiplano.

Peru

In Peru, PLAN International has been working very intensely on community participation aspects of IMCI with the collaboration of the MOH, PAHO, and UNICEF, particularly in areas north of Lima, such as Piura. After some pilot tests conducted in 1999, community IMCI will also be implemented in Chiclayo and adjacent areas.

E. BARRIERS TO IMPLEMENTATION

An initiative of this complexity will naturally encounter a series of barriers that impede its successful implementation. A number of these barriers have financial underpinnings; however, they are not listed under a separate category dedicated only to financial issues.

Institutional

Cultures

The partners represent very different institutional cultures—in their worldview, in their history, and in their way of operating. Although these differences were embraced in the original design as being supportive, they were exerting a net negative effect by the time of this evaluation.

Resistance to Integration of IMCI as an MOH Initiative

As of the time of this evaluation, the MOH of Guatemala had not officially adopted the IMCI strategy.

Indicators

Disagreements about the existing indicators and lack of agreement about new alternative ones have been a constant source of friction among the partners. Given that reporting on key indicators is not taking place, there is a great need for developing alternative indicators.

Appropriate Recognition

In Honduras, lack of recognition of the role of USAID as a funding agency for LACI activities hinders the maintenance of a good working relationship among the partners.

Collaboration and Communication

The initial proposal from PAHO and BASICS, “LAC Regional Results Package: Integrated Management of Childhood Illnesses (IMCI)—1997–2001” stated, “...close collaboration with USAID’s LAC and Global Bureaus, as well as USAID Field Missions, PAHO Country Offices and other agencies interested in IMCI—NGOs among them, will be sought through implementation.” (p. 2) However, as the evaluation team had the opportunity to observe, there was frequently insufficient, poor, or no communication among the different partners in this initiative.

Disagreement about the Community Component of IMCI in Honduras

While PAHO is promoting the use of the PAHO–UNICEF community IMCI approach and materials, BASICS and the World Bank are promoting the AIN program, which had previously been adopted by the MOH. Disagreements regarding these two different approaches are a major source of friction and have led to a weakening of collaborative efforts in Honduras.

Addressing the Nutrition Aspects of IMCI

Reportedly, health professionals, particularly medical doctors, have difficulties in effectively addressing nutrition problems identified through the IMCI exam. Identified as a weakness in the formal evaluation of IMCI in Bolivia, this issue should be worked out in modifying the training.

Supervision

In all three countries visited, supervision was noted as one of the weakest components to effective IMCI implementation. In some cases, as in Peru, the emphasis in supervision is more on administrative aspects than on technical and educational aspects.

Staffing

At all levels of partner institutions in IMCI, most of the key persons involved have other significant responsibilities. For those few persons for whom the regional IMCI initiative is their major job responsibility, the scope of this responsibility is too much for just one person or a small team.

Personal

Weaknesses in interpersonal communication skills among specific key individuals serve to magnify the management and communication problems experienced at the institutional level.

External

External factors, outside the control of any given partner, that have limited IMCI progress to date, include

- the downsizing of USAID worldwide and increased focus on Africa,
- Hurricanes Mitch and George,
- the predominance of political concerns over sound technical approaches that led to situations (such as in Bolivia) where the training course was shortened from 11 to 5 days in spite of the experts' opinion that it would negatively affect the quality of the training, and
- the frequent transfers or change of health personnel both at the central (MOH) and peripheral levels (districts, hospitals, and clinics), as well as in the implementing partners' structures.

F. FACILITATING FACTORS

Over the course of this initiative, different factors have facilitated its implementation, including political, institutional, financial, personal, and external.

Political

The success of an initiative of this nature is integrally connected with the ability to obtain approval and continual support of the key health and political authorities in the countries. Having obtained this high-level support at an early stage in seven out of the eight countries involved has allowed the process to move forward at a reasonable pace.

Institutional

As a regional initiative, the LACI initiated, stimulated, and funded activities that countries could not (tools) or would not (workshops and international meetings) necessarily support on their own. It did so through a wise choice of partners: PAHO had the reach and stability of a regional institution; BASICS had the program skills as an international development organization (versus the medical approach of PAHO), the specific technical skills, and had been more involved than PAHO in early stages of developing IMCI (e.g. the first adaptation in Zambia); and USAID provided the funding and management oversight. When PAHO and BASICS could go into a country together, they could talk to both the MOH and the USAID Mission. The strategic coordination of institutional strengths helped open up the IMCI dialogue in-country.

Obtaining the commitment of important national institutions, such as universities (medical and nursing schools) and pediatric societies, has been critical to the success of this initiative. Credit for this achievement is shared among the partners and their in-country colleagues and varies in degree from country to country. A case in point is the early support of the pediatric society in Bolivia, which contributed to the widespread acceptance of IMCI. In addition, the USAID/Bolivia bilateral project (CCH), which was implemented before IMCI, gave the LACI a head start—CCH had been operating in 11 districts, so IMCI started there even before the LACI. CCH paid for the first courses. The good working relationship among PAHO, BASICS, USAID/Bolivia, and the MOH existed from the time that project was implemented.

Financial

IMCI is so appealing as an effective health strategy that it has attracted complementary funding for the various IMCI components (e.g., Japanese funding for drugs in Honduras and American Red Cross funding for community IMCI in Honduras and other countries).

Personal

The overwhelming consensus of the persons interviewed is that IMCI is an effective strategy for identifying and treating sick children and thus preventing more serious medical sequelae or even death. It is possible to verify the positive results of IMCI for individual patients. Thus, individuals trained in IMCI who implement it correctly develop a strong commitment to the cause, a commitment that was repeatedly evident in the interviews conducted during this evaluation. In Bolivia, the head of the MOH's Department for Client Services (Departamento de Atención a las Personas, where Seguro Básico de Salud and therefore IMCI are housed) was the former president of the Bolivian Society of Pediatrics (thus well respected and connected). He himself was trained as an IMCI facilitator, which explains in part his commitment to IMCI.

High personal commitment to IMCI by key individuals throughout the system—from high-ranking administrators and managers to the health practitioners directly involved in treating patients—creates a positive climate for change and the effort needed to bring

about change in one's own behavior and that of one's colleagues and supervisees. Evidence obtained in the three countries visited shows that the LAC Regional IMCI Initiative is acting as an instrument of change in their respective health care systems.

External

In the three countries visited, the collaboration of other governments/international organizations has been critical for the implementation of the strategy and for obtaining additional funds to support IMCI activities throughout the country.

V. SPECIAL ACHIEVEMENTS OF THE LAC REGIONAL IMCI INITIATIVE

Based on interviews, observations, and visits in three different countries, IMCI has made substantial progress in the areas of advocacy, institutionalization of IMCI, coherence of IMCI's message, training activities, creation of tools and dissemination of experiences to other countries, ability to work under adversity, and sustainability.

A. ADVOCACY

Effective advocacy by PAHO, BASICS, and USAID/LAC Missions to MOHs, NGOs, and bilateral and multilateral agencies is manifested by seven out of eight countries having adopted the strategy and by the amount of funding obtained from other governments and agencies (USAID Missions, the World Bank, the Inter-American Development Bank, and PVOs) to carry out in-country IMCI activities. Because of its special relationship with governments and ministries of health, PAHO has been particularly effective in its advocacy role. As a result, there has been a strong political commitment by health authorities at national, regional, and local levels to this initiative.

B. INSTITUTIONALIZATION OF IMCI

In Honduras, the Secretary of Health has officially adopted the IMCI strategy.

In Bolivia, IMCI has strong support from the Ministry of Health, as well as from academic institutions in the country, such as the Sociedad Boliviana de Pediatría. The IMCI protocol has been incorporated into the MOH's overall protocol for health services for children under five (Seguro Básico de Salud). The document which manifests this integration (Guías Técnicas para la Atención del Seguro Básico de Salud) was a product of the efforts of many institutions in Bolivia, among them the MOH, UNICEF, BASICS, and PAHO.

In Peru, the Ministry of Health has officially adopted IMCI. In December of 1997, a Comisión Nacional Coordinadora AIEPI was created in the Ministry and has been functioning actively since then. IMCI activities complement the strategy called Proyecto de Capacitación Materno Infantil (PCMI), which is financed by USAID as part of Proyecto 2000 and also with funds from the Peruvian government. In addition, both Bolivia and Peru have very active interagency committees that provide effective support to IMCI activities in the country.

C. COHERENCE OF IMCI'S MESSAGE

One key factor in introducing a new strategy, for example, IMCI, is to maintain the integrity of the message, regardless of the persons conveying that message, and regardless of the audiences receiving it. Thus far, it appears that the IMCI message has been maintained over space and time in the three countries visited. This message has been effectively conveyed in different countries, by many different collaborators, under very different political and cultural situations, and yet the message has not been distorted nor diluted. Through the interviews and field visits to three countries, a clear and consistent message was communicated regarding the challenges and promises of IMCI.

D. TRAINING ACTIVITIES

Although in-country training in itself is not part of the regional initiative, its quality is related to the quality of the training manuals and the expertise of the trainers. The initiative's activities have had a direct bearing on these latter two components. As a result of the effectiveness of IMCI training activities:

- more than 8,000 people have been trained in this strategy, including physicians, nurses, and auxiliary nurses;
- the trainees interviewed have shown sound knowledge of the IMCI strategy;
- there is a growing tendency to look at the health of children from a holistic point of view as opposed to having specific diseases to be managed by vertical programs;
- there is a clear awareness by mothers, promoters, and other community leaders of their role in keeping children healthy;
- mothers are being counseled more effectively at health centers;
- health workers manage drugs more appropriately;
- pneumonia is diagnosed more quickly and accurately in children;
- health workers have improved their referral capacity, particularly for pneumonia and diarrheal diseases; and
- there is the perception (not yet quantified) that IMCI has diminished children's deaths by pneumonia and diarrheal diseases.

In Peru, the initial 11-day IMCI training course was adapted and shortened to 7 days by the MOH, keeping the main components of the original course. Peru's example has been enthusiastically adopted and implemented in Honduras, which has led to its wide

application throughout the country. Other countries in the region have shown interest in the 7-day version.

E. CREATION OF TOOLS AND DISSEMINATION OF EXPERIENCES TO OTHER COUNTRIES

An RPM tool was developed by Management Sciences for Health, which was financed by USAID through BASICS, with the collaboration of PAHO. This tool has been successfully field tested in Bolivia and Ecuador and the results indicate that this activity could profit from expansion to other countries with regional funds support.

In Bolivia, LACI funds have supported COTALMA in developing materials for community IMCI activities and a related package of materials (Complementary IMCI) for training auxiliary nurses. Other materials to support community IMCI efforts were developed in Honduras prior to the introduction of IMCI itself. These materials, which are part of the program called AIN Comunitario, have now been exported to Ecuador and Nicaragua and eventually will be sent to other Central American countries with World Bank support. AIN is also being considered by PAHO for inclusion among IMCI training materials.

In addition to the tools, the regional meetings sponsored by the initiative are effective for the exchange of information and experiences among the different countries. PAHO's regional advisers actively participate in international meetings connected with the application of the IMCI strategy in Latin America (e.g., Durban, South Africa, meeting on IMCI, where WHO invited IMCI's regional advisors to participate and share their experience). In that regard, many among those interviewed expressed their belief that of all the regions, Latin America was the most advanced in the implementation of the strategy. PAHO's Meta 2002 strategy (Goal 2002—their regionwide vision for reducing infant and child mortality over the next three years) has proved to be an effective marketing strategy for IMCI and will likely help mobilize additional resources.

F. ABILITY TO WORK UNDER ADVERSITY

One of the remarkable results of introducing IMCI has been the stimulation of active and dedicated participation of health staffs and communities, sometimes at considerable personal cost. The examples below are related to the personal commitment characteristic that was discussed earlier as a facilitating factor. The high quality of inputs from LACI (e.g., materials, development of national training teams, technical assistance) has contributed to positive change in key role models (individuals as well as institutions) in the three countries visited. Their commitment to IMCI serves as a powerful motivating force for their colleagues.

Although Honduras was devastated by Hurricane Mitch, interviewees did not mention this as a major obstacle (or did not mention it at all), which suggests that they have extraordinary commitment and enthusiasm to overcome this obvious tremendous obstacle. Health workers are not using Mitch as an excuse for being behind or for

resources having been re-directed to deal with the hurricane's aftermath. Perhaps part of the reason for their sustained enthusiasm is that they see that IMCI works in their own health centers. The MOH and the facilitators remain enthused because the course maintains its standard level of quality and they are rewarded by the motivation of the trainees.

In Bolivia, one of the facilitators gives up her vacation days in order to work as a facilitator because she cannot take the time off officially from her regular job. In Peru, one doctor, the head of a health center, undertook a study of the change in the use of antibiotics in 7 rural and urban health centers, analyzing 800 cases before and after the implementation of IMCI. He did this in his spare time, after the normal working hours of his own center and those he visited.

G. SUSTAINABILITY

Several ways of working towards the sustainability of the IMCI strategy have been implemented in the countries visited. Although they are not directly connected to the use of regional funds, they show a commitment from those involved for making long-lasting changes through IMCI. Examples of progress toward sustainability of IMCI include its incorporation into the policies of the ministries of health, expanding its base of financial support through other agencies and governments' participation, and the intersectoral collaboration with the education sector. For example, in Peru, one motivated medical doctor in charge of a periurban health center (Cura Mori, Piura) has developed a strong cooperative relationship with the primary school. Activities undertaken include training teachers and school health agents to assist with de-worming of students, detection of anemia and guidance for chlorinating household drinking water, and training students to serve as health advocates among their peers and their own families.

The use of both mothers and promoters as effective channels for the delivery of IMCI messages within their communities is another example. Due to the complementary role of providers of health services (e.g., MOH) and consumers (mothers and children), the potential for services to be mutually acceptable increases when community members speak the same language and understand the same messages as do the health providers. Thus, training in the community component of IMCI is critical to increasing the overall impact of the strategy.

IMCI has been incorporated into the curriculum of nursing and medical schools. In the three countries visited, IMCI has been introduced, to different degrees, into the curricula of nursing and medical schools. In Honduras, the nursing school in Choluteca, CERARH-Sur, has integrated IMCI into the students' study plans. In Bolivia, IMCI has been integrated into two medical schools, San Simon (Cochabamba), and the University of San Andres (La Paz), and in the Nur School for auxiliary nurses in Santa Cruz. In Peru, IMCI is integrated into the medical school, Universidad Nacional Pedro Ruiz Gallo (Chiclayo). In this way, future health providers are being trained through normal school channels, which will eventually eliminate the need for separate (and expensive) IMCI initial training activities.

The impetus for the above initiatives related to curriculum changes derives in large part from members of the original national training teams. As they proceeded with replicating IMCI training in-country, they realized what a tremendous task lay ahead in training all the current MOH health providers. They also realized that it is easier to introduce a new concept (IMCI) to a student undergoing her/his initial professional training than to try to convince a seasoned practitioner to change ingrained approaches and behaviors.

VI. CONCLUSIONS

A. OVERALL

Progress to Date

Based on interviews, observations, and visits in three countries, the LACI has made substantial progress towards the Strategic Objective of providing more effective health services to children in response to CDD, ARI, and malnutrition. As expected, the degree of implementation of the various components of IMCI varies by country and within country: in some areas, activities are in the pilot testing phase (e.g., community IMCI in Peru and Bolivia) and other areas have reached a point of moderate expansion (e.g., intensive expansion of the clinical training by the MOH in Honduras). Even though the momentum of the LACI slowed down somewhat in the past 12 months, as reported in USAID's LAC Regional R4 report (March 22, 2000), this has not been a major detriment to overall progress.

Key representatives of all stakeholders in Washington and in the three countries visited expressed their keen interest in the findings of this evaluation. This positive attitude bodes well for regaining any lost momentum, making appropriate midcourse corrections, and achieving the overall goals by the end of the five-year period.

The most significant obstacles to progress (summarized in following sections) stem from a combination of issues related to project design, management, and an overemphasis in-country on clinical training, to the detriment of improving critical health support systems. If these obstacles can be addressed effectively and in a timely manner, it is possible that LACI will accomplish the majority of its five-year goals in those countries that have participated actively (i.e., in possibly five or six of the eight target countries) and stimulate the more effective application of the strategy in other countries in the region.

It is the people, as individuals and in teams, whose dedication to the IMCI philosophy and practice makes it possible to carry forth and rise above all of the problems that they face in implementing IMCI within their own spheres of influence. These people have participated, either directly or indirectly, in activities supported by the LAC Regional IMCI Initiative. The high quality of the initiative's inputs and activities has contributed significantly to creating a positive and supportive environment for change.

Role of LAC Regional IMCI Initiative as a Catalyst

The LAC IMCI Regional Initiative has functioned as a true catalyst, albeit not the only one, for IMCI in the region. It joined the efforts of other agencies and governments to accelerate the adoption of IMCI, such that the changes introduced have real potential for becoming part of the daily routine of health facilities, including hospitals, health centers,

and health posts in rural areas. Midway into the five-year initiative, concrete evidence of interest for working at the community level was found, and a set of actions are planned in that regard in the countries visited. As a catalyst, USAID/LAC is taking some risks, in the sense that it cannot predict nor control some of the outcomes of the activities it is supporting in a group of very different countries. The fact that the outcomes have been so positive to date is a real credit to USAID/LAC and the partners it chose for this effort.

Unique Contribution

Given a state of almost tabula rasa of IMCI in Latin America at the beginning of LACI, USAID/LAC and its partners had to gamble that the activities they chose for funding would be viable, practical, economical, complementary, and that they would fulfill the desired purpose. The findings of the evaluation suggest that these activities have been strategic—in their content, timing, budgetary support, and location. Many of these activities are ones that other IMCI supporters, especially local ministries of health, could never have financed themselves (e.g., adaptation of manuals, creation of new materials, a national evaluation) or would not have been considered priorities within their limited budgets (e.g., participation in international workshops to address specific IMCI issues). In this regard, the LACI contribution has been unique and absolutely critical to the IMCI adoption process.

LACI-supported activities are leading to some benefits beyond those contemplated for IMCI itself. In all countries visited, IMCI is already showing promise as an organizing paradigm for other non-IMCI services provided in the clinic. IMCI introduced the technique of triaging for danger signs and immediately referring emergency cases to the most qualified staff person available; this system of triaging is now accepted as a logical way to identify any emergency case that arrives. IMCI also introduced a very specific concern for quality of care as reflected in waiting time at the clinic, teaching health providers how to communicate respectfully with patients, making sure caregivers understand the instructions for home care. This concern for client satisfaction has easily been applied to the whole clinic clientele, not only IMCI patients.

Window of Opportunity

There is great interest in IMCI right now, across the breadth of persons interviewed and the depth of locations visited. The window of opportunity for IMCI currently is open, but it is finite and probably will be shutting in the not-too-distant future as interest (and donor support) increases in maternal and perinatal mortality and/or is shifted due to an unforeseen emergency.

B. PROJECT DESIGN

Overall

In general, the overall design of the LACI is sound; the major problems have been experienced in the implementation of the design.

Indicators

The indicators for the SO and IRs 3 and 4 are not adequate to capture the progress of LACI activities.

Choice of Countries

The reluctance of Guatemala to participate in IMCI has been a distraction and has used valuable resources with little result. Other countries could make better use of the resources planned for Guatemala and any other country, such as Haiti, which has not actively engaged in LACI as of the time of this evaluation.

C. MANAGEMENT AND ADMINISTRATION

Steering Committee

The steering committee is not functioning as satisfactorily as it could (e.g., compared with the steering committee of the LAC Health Sector Reform Initiative) nor as it should in order to make the most of the human, financial, advocacy, and networking resources available to it. The LACI is designed with great expectations and great potential for synergy in planning, implementation, and coordination among the different partners. Organizational and personality conflicts are preventing this synergy from happening to the extent possible.

Given the turnover in the steering committee and the availability of the evaluation results, now would be a good time to regroup, reflect, and recommit to the initiative. In the words of one interviewee, “Partnerships need to be coordinated; they don’t grow up naturally.”

In-country Coordination

In most target countries for the LAC Regional IMCI Initiative, both partners (PAHO and BASICS) have in-country representation. There needs to be a focal point for LACI communications in each country for the purpose of efficient and effective communication within the country and between the countries and USAID/LAC.

Receiving Credit

IMCI is owned by everyone; thus, USAID is one of many donors participating in this global effort. The LAC Regional IMCI Initiative is not receiving the credit it is due, especially within countries where funds are dispersed through several channels and lose their identity.

D. IMPLEMENTATION

Facilitating Factors

The quick adoption of IMCI by seven of the eight participating countries is indicative of the political support given to this strategy. The LACI design, choice of experienced partners, advocacy with other collaborators, and local USAID support have all come together to help effect the positive results noted by the evaluation team. In addition, expansion of IMCI is being conducted in many countries through coordination with the Child Survival Resources and Collaboration group of PVOs.

Obstacles

This project has had its share of normal obstacles (e.g., turnovers in key personnel, late reports, difficulty in reporting on indicators). However, the one thing that seems to hold it back the most is the difficulty in working together (between and among the partner agencies).

Overemphasis on Clinical Training and Underemphasis on Health Systems Support Components

In the three countries visited, IMCI training activities are expanding too fast, to the detriment of the other system components (i.e., attention to quality of services, supervision, and integration of the IMCI indicators into the HIS; monitoring and evaluation; management and cost analysis of IMCI drugs; health facility assessment; overall cost analysis of adopting IMCI). Many tools already exist for helping countries incorporate IMCI into their health management and administration systems. Developed by the LACI partners, these tools are not sufficiently promoted nor have they been adopted in the areas visited in Honduras, Bolivia, and Peru. If more attention is not given to these IMCI system support components very soon, LACI will not be able to adequately capture the true depth nor breadth of its results at the end of the five-year project.

Community Component of IMCI–Honduras

If the conflict between the two approaches to community IMCI is not adequately resolved soon in Honduras, the country runs the risk of not only slowing down its IMCI implementation, but even losing progress gained so far. An agreement needs to be reached—and compliance promised—for the more effective implementation of AIN and AIEPI Comunitario where they will play complementary and not competing roles. This agreement will need a strong advocacy role from the MOH and PAHO and could have a significant contribution from COMSAIN. PAHO, BASICS, and USAID—in the forum of their LACI steering committee and in the forum of their respective representatives in Honduras—need to reach mutual consensus on how to proceed with community IMCI in Honduras. The way this disagreement is solved in Honduras can set an example for similar approaches to problem solving at the regional level.

E. SUSTAINABILITY

As of the time of this evaluation, the LACI shows great promise for making a major contribution to the eventual sustainability of IMCI within nationwide health systems in the participating countries. Currently, there are five different approaches being pursued to promote sustainability, all with initially promising results, although mostly on a limited and pilot basis to date:

- incorporation of IMCI into MOH policies,
- stimulation of donor support and funding for the expansion of IMCI,
- incorporation of health issues into activities of the education sector,
- training community-based health promoters and mothers in IMCI messages, and
- incorporation of IMCI into the curricula of nursing and medical schools.

VII. RECOMMENDATIONS

Through the IMCI Initiative, USAID/LAC has made a unique contribution to the implementation of this strategy in Latin America. It has done so through a well-designed and flexible framework and approach to providing financial support for regional activities not usually financed either by country USAID Missions, governments, or international bilateral agencies. These efforts should continue to be supported to improve the health status of children throughout the hemisphere. The recommendations that follow are directed towards USAID/LAC and the two partners (PAHO and BASICS), as specified.

A. RECOMMENDATIONS TO USAID/LAC

Funding

Continued funding should be provided to LACI, which has led to many important achievements in spite of some obstacles. Although USAID/LAC cannot accept funds from other sources, they can support the fundraising efforts of others (especially those already underway by PAHO and the ministries of health) to expand and enhance IMCI in the Americas, particularly through in-country activities.

Resources

Remaining LACI resources should be invested only in those six target countries that have so far been active participants in the initiative, unless health authorities in Guatemala and Haiti show greater interest in having the initiative implemented in their respective countries.

Steering Committee

Although considerable progress has been achieved in terms of improving the collaboration between BASICS and PAHO, the steering committee could profit from three distinct but related actions:

- having each member empowered by her/his institution with a level of decision-making authority appropriate to the critical managerial role of the steering committee;
- reaching an understanding among the partners regarding the different institutional cultures and the need to address these differences more effectively, such as by conducting teambuilding activities with an outside facilitator; and

- redesigning the remaining annual work plans and budgets to include a clear delineation of roles and responsibilities between both implementing partners.

Indicators

Because of the regional nature of the project, indicators should be adapted to regional activities. Indicators for the overall Strategic Objective and for Intermediate Results 3 and 4 should be revised and baseline and annual data should be reported.

B. RECOMMENDATIONS TO PAHO AND BASICS

Compliance

PAHO and BASICS reports and work plans should be sent to USAID/LAC on a timely basis. New staff for the initiative should be approved by USAID, according to the terms of their agreements.

Appropriate Credit

In several instances, the source of financial support for LACI activities was not properly acknowledged. It is important that appropriate credit be given, according to the terms of PAHO's and BASICS' agreements with USAID.

C. RECOMMENDATIONS TO ALL PARTNERS (USAID, PAHO, AND BASICS)

Communication among the Partners

Flow of communication between USAID/LAC and the USAID country Missions, as well as between PAHO and BASICS with USAID Missions, should be increased, which could lead to a more effective integration of activities at the local level.

IMCI Support Systems

Until now, the emphasis of IMCI at the country level has been on the introduction and expansion of training activities. However, this should not be done in detriment of improving other components (supervision, monitoring and evaluation, HIS, and drug management), which are equally critical. In addition, training lessons were better learned when follow-up activities were conducted to reinforce the training, showing the importance of redesigning training plans to make them complete.

Sustainability

Sustaining IMCI should be reinforced by continuing efforts at integration into nursing and medical schools' curricula, as well as by obtaining additional sources of financial support. Also important is the continuation of joint implementation activities with NGOs

(such as Plan International and CARE). In addition, new programs and organizations should be contacted and made part of this initiative. Ultimately, the sustainability of the IMCI strategy will be another measure of success of this already worthwhile initiative.

D. PRIORITY OF ALLOCATING RESOURCES FOR IN-COUNTRY ACTIVITIES

Given the limited resources of the LACI budget and time, the priority of the following three activities should be

- improving IMCI support systems,
- introducing and expanding the community IMCI component, and
- undertaking efforts to promote sustainability.

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ANNEX A
IMCI ACTION MEMORANDUM

MIDTERM EVALUATION OF THE LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS INITIATIVE

USAID



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

FEB 22 1997

ACTION MEMORANDUM FOR THE ASSISTANT ADMINISTRATOR, LAC

FROM: LAC/SPM, *Janice Weber*

SUBJECT: LAC Regional - Health Priorities (598-0825):
Integrated Management of Childhood Illness

ACTION REQUESTED: That you approve the use of \$5 million for implementation of integrated management of childhood illness (IMCI) activities which support the LAC Regional Strategic Objective (SO) of "more effective delivery of selected health services."

BACKGROUND: The IMCI initiative is one of three initiatives which support the LAC Regional SO and focuses specifically on improving child health services. Four Intermediate Results (IRs) will contribute to this: (1) country health leaders have information for IMCI adoption; (2) country plans and strategies in place for introduction and implementation of IMCI; (3) improved country capacity to implement IMCI services; and (4) monitoring and evaluation used to adjust IMCI program plans. The IRs are to be achieved by Pan American Health Organization (PAHO) and the Global Bureau's BASICS project. Of the \$5 million proposed for this initiative, LAC/RSD plans to obligate \$1.5 million in FY 97.

DISCUSSION: A joint proposal from PAHO and BASICS to implement the IMCI initiative was reviewed at an Issues Meeting on January 28, 1997. The topics addressed are listed below. Although it was agreed that the initiative should be finalized for AA/LAC approval, an issue involving the refund to USAID of interest earned on advances must be resolved prior to signing the agreement with PAHO.

Recently, the Standard Provision requiring a refund of interest earned on advances was reinstated after GC determined that the interim clause permitting retention of interest was erroneous. PAHO does not agree to this clause (although they did so years ago) and the matter is in dispute. GC/LAC and LAC/RSD/PHN are continuing discussions with PAHO; but the matter has not been resolved. So that we can move quickly to obligate funds when the issue is finally resolved, we are seeking your approval of the initiative at this time with the understanding that no funds will

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

be obligated with either PAHO or BASICS for implementation of the IMCI initiative until a satisfactory resolution has been reached.

The following topics were addressed at the Issues Meeting:

1. Coordination with Missions - The proposal explained the working relationship between the implementing agencies and USAID/W, but contains very little about the involvement of Missions in the program's design and implementation, or about the relationship between the regional and bilateral programs. Coordination and communication with all partners will be very important, particularly as most of the target countries for the regional initiative have requested support from BASICS to implement various aspects of their bilateral IMCI programs. BASICS already actively coordinates with USAID field staff and LAC/RSD will continue to facilitate communication/coordination with Mission programs. In August, Missions were sent a copy of the Results Framework and the final proposal for their comment. While the responses received were uniformly favorable, Missions reiterated the necessity of good communication and coordination. Appropriate language will be included in the PAHO agreement emphasizing the need to coordinate with all partners. *

2. Participation of Non-Presence Countries - While representatives of non-presence countries may be invited to participate in IMCI activities, LAC Regional funding will not be used to pay for their participation. PAHO has already indicated its willingness to pay for the participation of non-presence countries in some cases. Appropriate language to this effect will be included in the grant with PAHO. *

3. Funding - In recognition of possible budget reductions, reviewers discussed the effect on project activities should less than \$5 million be available. If relatively small budget cuts were necessary, workshops/conference could be cut back or slowed down. Larger cuts would necessitate adjustments in training and delays to other activities, and Missions might be asked to consider funding some of the activities under their own programs. In addition, activities could be extended over a longer period than now planned. Severe cuts would require a re-examination of the program to determine how to proceed.

In finalizing the Bureau's FY 97 OYB, it was necessary to increase the SO's planned FY 97 obligation by \$1 million to compensate for a \$1 million shortage in FY 98. To accommodate the reduced FY 98 funding, FY 97 obligations for BASICS and PAHO will be greater than originally planned. It is anticipated that these adjustments will have minimal affect on program implementation.

4. Customers - Customers and their involvement in the IMCI initiative was discussed. Although not identified as such in the proposal, the customers are the Ministries of Health (MOH) and other providers of child health services in the LAC region. In

MIDTERM EVALUATION OF THE LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS INITIATIVE

the early design phase of the IMCI initiative, a representative of LAC/RSD visited the LAC region and met with the various MOHs, NGOs, other donors and Mission staff to discuss how the planned regional initiative could best support bilateral and country efforts. Feedback was taken into account as the proposal was more fully developed. The MOHs are the conveners of the Interagency Coordinating Committee (ICC) which will meet periodically to review experience and suggest improvements in the implementation of IMCI activities, thus ensuring continuous customer feedback.

5. Feasibility Analyses - It was agreed that the appropriate analyses (technical, administrative, financial, economic, etc.) have been adequately addressed. It was suggested that as part of the operational research activities an evaluation be undertaken to determine if the integrated approach is more effective, less costly, results in better care, etc. The proposal (which will serve as the Program Description for the PAHO and BASICS agreements) will be modified to include the evaluation as one of the research topics to be undertaken.

Environmental Determination: An Initial Environmental Examination (IEE) was approved by the LAC Chief Environmental Officer on February 13, 1997. The Chief Environmental Officer found that technical assistance and activities relating to integrated management of childhood illness qualify for a categorical exclusion, since these activities will not have an effect on the natural or physical environment. However, since the full extent of activities may not be identified, as inferred from the phrase "AID funds will be used primarily for technical assistance, pilot studies and dissemination of regional prototype materials and research findings," a supplementary IEE with recommended threshold decision will need to be submitted to the Bureau Environmental Office for activities not identified in the current IEE.

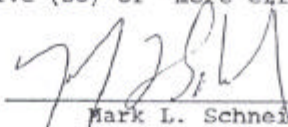
Statutory Requirements: The activities comply with statutory requirements outlined in the FY 97 Statutory Checklist. USAID funds may not be expended for assistance to Cuba, without the prior written concurrence of USAID. Language to this effect will be included in the grant to PAHO.

Congressional Notification: A Technical Notification for the Health Priorities activity was sent to the Hill on November 8, 1996 and expired without objection on November 22, 1996.

AUTHORITY: ADS 103.5.8b 1 and 2a give the AA/LAC the authorities to implement approved SOs and to negotiate, execute, award and implement agreements with public international organizations (PIOs), including PAHO. ADS 308.5.3 states that grants to PIOs are appropriate when considered more effective and efficient than direct USAID assistance in achieving a particular development assistance objective; the program and objectives of the PIO are compatible with those of USAID; the PIO is responsible; and the

grant is made for specific activities of interest to USAID, not to augment the PIO's general budget. By approving this memorandum, AA/LAC confirms that these conditions have been met.

RECOMMENDATION: That by signing below, you approve the use of \$5 million for implementation of IMCI activities which support the LAC Regional Strategic Objective (SO) of "more effective delivery of selected health services."


 Mark L. Schneider
 Assistant Administrator, LAC

3/5/97

Date

Attachment: Joint Proposal from PAHO and BASICS

Clearances:

DAA/LAC:NParker gop Date 3/2/97
 LAC/RSD:TJohnson (Draft) 2/11/97
 LAC/RSD-PHN:CDabbs (Draft) 2/5/97
 LAC/DPB:RMeehan (Draft) 2/11/97
 GC/LAC:SAllen (Draft) 2/27/97
 LAC/SPM:ERupprecht Em Date 2-22-97
 LAC/SPM:GBertolin (Draft) 2/14/97

Drafted:LAC/SPM:SHill:Revised 2/26/97:U:\shill\docs\imcimemo.sh

ANNEX B
GRANT TO PAHO

MIDTERM EVALUATION OF THE LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS INITIATIVE



U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

*Assistant
Administrator
for Latin America
and the Caribbean*

May 20, 1997

RECEIVED
LEGAL OFFICE
PAHO/WHO
97 MAY 21 PM 4:51

Dr. George A. O. Alleyne
Director
Pan American Health Organization
525 23rd Street, N.W.
Washington, D.C. 20037

SUBJECT:
Health Priorities Project, 598-0825
Integrated Management of Childhood Illness Component
Grant No. LAC-G-00-97-00001-00

Dear Dr. Alleyne:

I am pleased to inform you that, pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the Government of the United States of America, acting through the U.S. Agency for International Development (hereinafter "USAID") hereby grants to the Pan American Health Organization, Regional Office of the World Health Organization (hereinafter "PAHO" or "Grantee"), the sum of Eight Hundred and Forty Thousand United States Dollars (U.S. \$840,000) (the "Grant") to be used to support a program to reduce child morbidity and mortality in Latin America. The purpose of this grant is to promote more effective delivery of child health services in response to diarrheal disease, acute respiratory infection and malnutrition. The objective will be accomplished through implementing the Integrated Management of Childhood Illness (IMCI) strategy which is more fully described in Attachment 2, entitled "Program Description."

This Grant is effective and obligation is made as of the date of this grant and shall apply to expenditures made by the Grantee in furtherance of program objectives during the period beginning March 5, 1997 and ending December 31, 2001.

This Grant is made to the Grantee on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment 1 (the Schedule); Attachment 2 (the Program Description); and Attachment 3 (the Standard Provisions), all of which have been agreed to by your organization.

320 TWENTY-FIRST STREET, N.W., WASHINGTON, D.C. 20523

Please indicate your acceptance of this Grant by signing the original and three copies of this letter in the space provided below and returning the original and one copy to the Grant Officer. Please retain two copies for your files.

Agency for International Development

By: Mark L. Schneider
Mark L. Schneider

Title: Assistant Administrator,
Bureau for Latin America
and the Caribbean

Date: 5/20/97

ACCEPTED: Pan American Health Organization

By: George A. O. Alleyne
George A. O. Alleyne

Title: Director

Date: 97-5-23

Attachments:



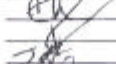




1. Schedule
2. Program Description
3. Standard Provisions

Schneider to Alleyne pg. 2

MIDTERM EVALUATION OF THE LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS INITIATIVE

Drafter: SLutjens, LAC/RSD-PHN, 7-9488,
doc:u:\drpub\hpn\hpp\IMCI\limcigrt.ltr

Clearances:

LAC/RSD-PHN:CDabbs		Date	3/31/97
LAC/RSD:SEpstein		Date	3/31/97
LAC/GC:SAllen		Date	3/31/97
LAC/DPP:CStradford		Date	4/1/97
LAC/DPP:RMeehan		Date	4/1/97
LAC/SPM:SHill		Date	5/1/97
DAA/LAC:CLEonard		Date	5/13/97

Fiscal Data

Appropriation: 72X1095
Project Number: 598-0825, Health Priorities Project, IMCI Initiative
Obligation Number: LAC-G--00-0097-00001-00
Fiscal Year 1997
Funds Account: DV96/97/LDV697
Total Obligated Amount: \$ 840,000
Paying Office: M/FM/CMP/GIB
Total Estimated Amount: \$4,810,281

LAC Bureau: Washington
Office of Regional Sustainable Development
More Effective Delivery of Selected Health Services
Health Priorities
IMCI Initiative
PAHO Grant

Resource Category Code: Grants, Subsidies, and Contributions (410463)

Entity:
LOC #

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Grant No. 598-0825-G-00-7-007-00

SCHEDULE

A. Purpose of Grant

The purpose of this Grant is to provide support for the PAHO activities in the Integrated Management of Childhood Illness (IMCI) component of the USAID Health Priorities Project. This initiative will serve to promote more effective delivery of child health services in response to diarrheal disease, acute respiratory infection and malnutrition.

The program will be implemented jointly by PAHO and the Partnership for Child Health Care Inc., the Cooperating Agency which implements the Basic Support for Institutionalizing Child Survival (BASICS) Project, as more fully described in Attachment 2 (the Program Description) of this Grant.

B. Period of Grant

1. The effective date of this Grant is the date of this grant. The expiration date of this Grant is December 31, 2001.
2. Funds obligated hereunder are available for program expenditures for the period from March 5, 1997 to July 31, 1998 as shown in the Grant Budget.

C. Amount of Grant and Payment

1. The total estimated amount of this Grant for the period shown in B.1. above is \$2,810,281 for regional activities, plus up to an additional \$2,000,000 in potential add-ons from USAID country missions for related activities.
2. USAID hereby obligates the amount of \$840,000 for program expenditures during the period set forth in B.2. above and as shown in the Grant Budget.
3. Payment shall be made to the Grantee in accordance with procedures set forth in Attachment 3 (the Standard Provisions). The Parties, PAHO and USAID, agree that, within the meaning of the first paragraph of the Standard Provision entitled "Refunds", as determined by PAHO's financial rules and accounting procedures, no interest will be earned on USAID funds paid to PAHO under the grant either (a) prior to expenditure of the USAID funds for program purposes under the grant, or (b) prior to expenditure of an equivalent amount of PAHO's funds for program purposes under the grant, for which PAHO has not previously requested payment by USAID under the

Schneider to Alleyne pg. 4

Grant No. 598-0825-G-00-7-007-00

grant.

4. Additional funds up to the total amount of the grant shown in C.1. above may be obligated by USAID in increments subject to the availability of funds, the mutual agreement of the Parties to proceed, and the requirements of the Standard Provision of the Grant entitled "Revision of Grant Budget."

D. Grant Budget

The Grant Budget is shown in Appendix F, Attachment 2 (the Program Description) of this Grant. Revisions to the Budget shall be made in accordance with the Standard Provision of this Grant entitled "Revision of Grant Budget".

E. Reporting and Evaluation

1. The PAHO Grant Manager will submit to the USAID Grant Manager at LAC/RSD-PIIN, Room 2247A NS, U. S. Agency for International Development, Washington, D. C. 20523, a semi-annual technical report covering implementation progress and projecting activities for the next reporting period by intermediate results as described on page 21 and 22 of Attachment 2, the Program Description.

The annual technical report covering the previous calendar year will include a summary, organized by Intermediate Results, of activities, accomplishments and any impediments in implementation including a report on indicators at the goal, Strategic Objective, and Intermediate Result levels.

Each technical report will also be copied to the Global Bureau and the Population and Health officer at the USAID mission in each of the eight target countries for this initiative. The USAID Grant Manager will provide PAHO with the list of names and addresses, and any changes as they occur.

Semi-annual reports will be due no later than July 31 and annual reports no later than January 31 of each calendar year.

The quarterly financial reports will be sent to M/FA/FM/CMP/GIB, Room 100, SA-2, Washington DC 20523, with a copy to the USAID Grant Manager and any USAID mission which has provided add-on funds to this grant. The financial report will show expenditures of both USAID and PAHO project

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MIDTERM EVALUATION OF THE LATIN AMERICA AND THE CARIBBEAN
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS INITIATIVE

Grant No. 598-0825-G-00-7-007-00

funds and make projections for expenditures of PAHO and USAID funds for the next reporting period.

2. The Grantee shall prepare and submit 2 copies of all technical reports to the Bureau for Program and Policy Coordination, Center for Development Information and Evaluation, Development Information Division (PPC/CDIE/DI), to be mailed to:

Document Acquisition
PPC/CDIE/DI
Room 209, SA-18
US Agency for International Development
Washington, DC 20523-1802

The title of all reports forwarded shall include a descriptive title, the author's name(s), grant number, the project number and title, grantee's name, name of the grant officer, and the publication or issuance date of the report. The format of this report should be consistent with all LAC Bureau reports and will be provided to PAHO by the USAID Grant Manager.

3. A mid-term evaluation of this project will be conducted, with a final report to be available by the end of the third year. USAID will contract an independent team of evaluators. (Funds for the evaluation will not be granted to PAHO, but used directly by USAID to engage the evaluation team.) USAID will consult with PAHO on the composition of the evaluation team. The scope and terms of reference for determining the methodology will be agreed upon between USAID and PAHO.

F. Special Provisions

1. The Parties agree that this Grant and the activities financed therewith will be managed by the Grantee in accordance with its established policies and procedures.

2. By April 20, 1997, PAHO and USAID shall mutually agree to the job descriptions and personnel selected for key Grantee staff assigned to manage and administer the program, jointly funded by PAHO and USAID.

3. PAHO will participate in regular planning and reporting meetings with USAID and BASICS staff and as further described in Attachment 2 pages 20-

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Grant No. 598-0825-G-00-7-007-00

22 (under Program Management and Coordination in the Program Description).

4. Roles and responsibilities within the LAC Regional IMCI Technical and Management Group will be delineated in a Memorandum of Understanding to be developed and signed by PAHO and BASICS representatives by April 30, 1997.

5. PAHO may include representatives from non-target countries to attend regional and sub-regional events to promote the IMCI Initiative. However, funds provided by this Grant may not be used to pay the costs of travel or per diem of non-target country representatives without prior approval of USAID.

6. PAHO will submit an annual work plan and budget for expenditures to the USAID Grant Manager, which must be agreed upon by both organizations prior to implementation of the proposed work plan.

7. Present statutory and other authorities prohibit the use of USAID funding for programs in Cuba under this grant. USAID will inform PAHO in writing of other countries which may, because of statutory or other prohibitions, become ineligible to receive USAID funding during the life of this program or of countries to which statutory or other prohibitions no longer apply. PAHO shall consult with USAID regarding restrictions on assistance to the Government of Haiti.

8. No grant funds will be utilized for the purchase of motor vehicles not manufactured in the United States without the prior written concurrence of USAID. No grant funds shall be used for performing or promoting abortions.

9. PAHO agrees to consult with USAID regarding circumstances under which it would be appropriate to acknowledge USAID's contribution to the Program, such as invitations, materials for workshops, reports or other published materials. If requested by USAID, PAHO shall acknowledge USAID's contribution to the Program per the Standard Provision on "Publications and Media Releases."

10. The USAID Technical Office, including the USAID Grant Manager, responsible for monitoring this Grant is the Population, Health, and Nutrition team of the Office of Regional and Sustainable Development, Bureau for Latin America and the Caribbean (LAC/RSD-PHN), Room 2247A NS,

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Grant No. 598-0825-G-00-7-007-00

Washington, D.C. 20523.

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ANNEX C

USAID RESULTS FRAMEWORK

IMCI Initiative

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: IMCI Results package: More effective delivery of child health services in response to DD, ARI, and malnutrition.

SO 3 INDICATOR #2: Target countries with 10% of health facilities* delivering IMCI services

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS

INDICATOR DESCRIPTION:

a) *Health facilities defined as ambulatory health facilities, health centers and health posts.

b) Delivering services means at least one person trained in IMCI and continuous availability of IMCI drugs

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua, and Haiti

YEAR	PLANNED	ACTUAL
1996	--	0 (B)
1997	0	0
1998	3	No data
1999	5	No data
2000	7	
2001 (T)	8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions.

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: IMCI Results package: More effective delivery of child health services in response to DD, ARI, and malnutrition.

SO 3 INDICATOR #3: Target countries with 90% of health facilities in early use areas delivering IMCI services

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS

INDICATOR DESCRIPTION:

a) Health facilities defined as ambulatory health facilities, health centers and health posts.

b) Designated districts will be identified early in 1998 in collaboration with MOH/PAHO/BASICS

c) Delivering services means at least one person trained in IMCI and continuous availability of IMCI drugs

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua, and Haiti

YEAR	PLANNED	ACTUAL
1996	--	0 (B)
1997	0	0
1998	3	3
1999	5	3
2000	7	
2001	8 (T)	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions.

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.1; IMCI Results package: Country health leaders have information for IMCI adoption.

INDICATOR 3.2.1a: Target counties where Ministry of Health leaders have adequate information regarding IMCI.

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS Reports.

INDICATOR DESCRIPTION: Adequate information is defined as MOH have been briefed on the IMCI strategy, country requirements in order to implement (e.g. policies, human resources, drug management system, etc).

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti.

Year	PLANNED	ACTUAL
1996	--	0 (B)
1997	2	7
1998	8	8
1999	8	8
2000	8	
2001 (T)	8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions.

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.1; IMCI Results package: Country health leaders have information for IMCI adoption.

INDICATOR 3.2.1b: Target counties with official decision to adopt IMCI.

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS Reports

INDICATOR DESCRIPTION:

COMMENTS: Target countries for the IMCI Results package include: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti. Although Guatemala MOH officials had indicated that they would adopt IMCI, no actions have been taken since, so we do not count them as having made this decision.

Year	PLANNED	ACTUAL
1996	--	0 (B)
1997	2	7
1998	5	7
1999	8	7
2000	8	
2001 (T)	8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.2; IMCI Results package: Country plans and strategies in place for introduction and implementation of IMCI

INDICATOR 3.2.2: Target countries with IMCI plans and strategies adopted including identification of resource requirements

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS Reports

INDICATOR DESCRIPTION:

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti.

*Until and unless Guatemala adopts IMCI, this cannot happen. No change since the mid-1999 election.

YEAR	PLANNED	ACTUAL
1996	(B)	0
1997	2	7
1998	4	7
1999	7	7
2000	8*	
2001 (T)	8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions

APPROVED: 3/97; IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.3; IMCI Results package: Improved country capacity to implement IMCI

INDICATOR 3.2.3a: Target countries where 80% of districts have developed plans for IMCI implementation.

UNIT OF MEASURE: Number/ Proportion

SOURCE: PAHO and BASICS Reports

INDICATOR DESCRIPTION:

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti.

YEAR	PLANNED	ACTUAL
1996	--	0 (B)
1997	0	0
1998	2	No data
1999	6	4
2000	8	
2001 (T)	8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions

APPROVED: 3/97: IMCI Results Package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.3; IMCI Results package: Improved country capacity to implement IMCI

INDICATOR 3.2.3b: Target countries with more than 10% of ambulatory health facilities in early use areas which have IMCI norms, trained health service providers, and IMCI essential drugs available.

UNIT OF MEASURE: Number SOURCE: PAHO and BASICS Reports INDICATOR DESCRIPTION: a) IMCI norms and trained health service providers; b) IMCI essential drugs available COMMENTS: Target countries for the IMCI Results package include: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti.	YEAR	PLANNED a/b	ACTUAL a/b
	1996	--	0 (B)
	1997	0/0	0/0
	1998	3/1	No data
	1999	6/3	No data
	2000	8/5	
	2001 (T)	8/8	

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions

APPROVED: 3/97; IMCI Results package

COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.2.4: Monitoring and evaluation used to adjust IMCI program plans.

INDICATOR 3.2.4: Target countries which have incorporated monitoring and evaluation findings into annual IMCI national plans

UNIT OF MEASURE: Number

SOURCE: PAHO and BASICS Reports

INDICATOR DESCRIPTION:

COMMENTS: Target countries for the IMCI Results package are: Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti.

YEAR	PLANNED	ACTUAL
1996	--	0 (B)
1997	0	0
1998	3	0
1999	5	3
2000	8	
2001 (T)	8	

ANNEX D

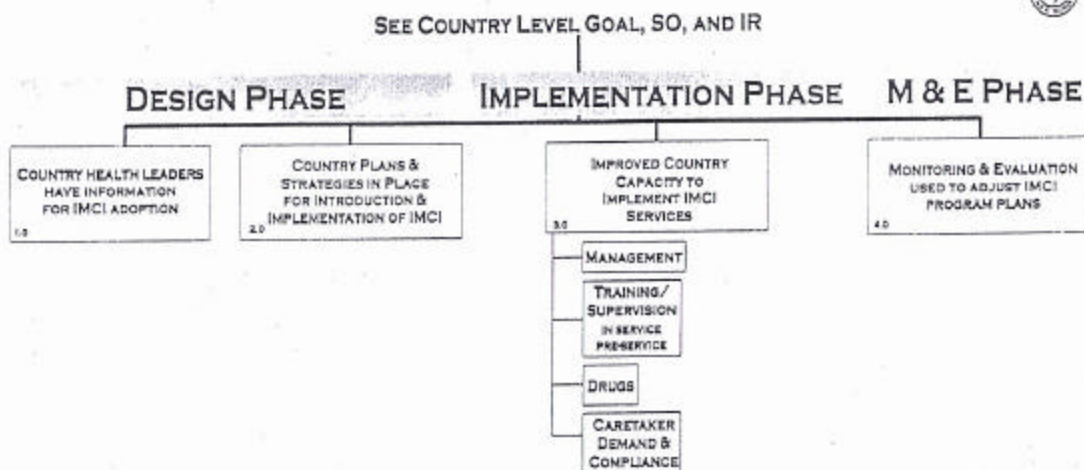
LAC IMCI SCHEMATIC DESIGN

11/20/98

LAC REGIONAL IMCI INITIATIVE

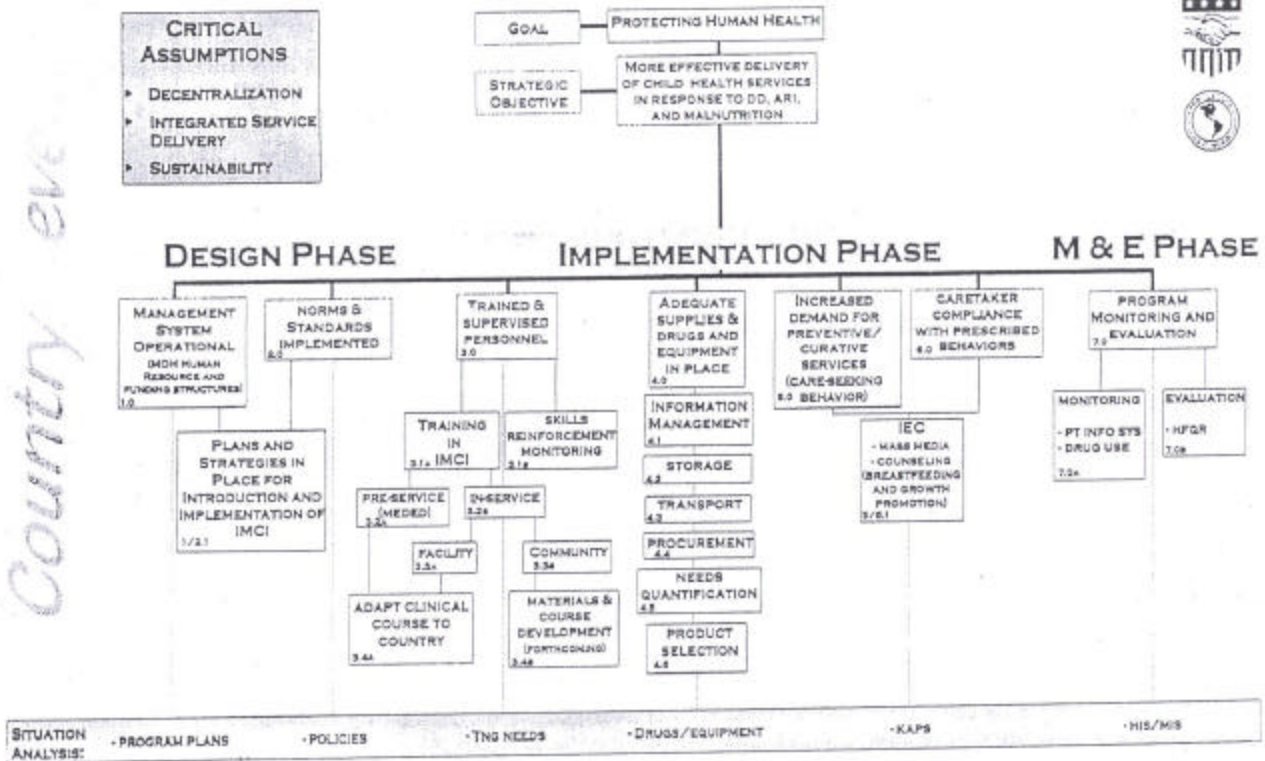


Regional level



11/20/96

LAC REGIONAL IMCI INITIATIVE



ANNEX E
SCOPE OF WORK

Scope of Work
Midterm Evaluation
Health Priorities Project, 598-0825
IMCI Initiative
30-August-99

Background

Worldwide some 12 million children die each year before they reach their fifth birthday. Approximately 565,000 of those deaths occur in Latin America and to a large extent are preventable. The majority of these deaths are attributable to diarrhea, pneumonia, measles, malaria, and malnutrition, or a combination of these conditions. Global burden of disease estimates have projected that these same illnesses will remain the most important causes of child mortality continuing into the year 2020 without increasing attention to address them.

Building on past experience and lessons-learned from disease-specific control programs, the World Health Organization (WHO), in collaboration with UNICEF, developed an integrated approach to the assessment, classification, treatment, and counseling of sick children and their caretakers. This approach is known as Integrated Management of Childhood Illness (IMCI) and forms the basis for new treatment guidelines at first-line health facilities. IMCI provides for integrated case management of the most common childhood illnesses (acute respiratory infections, diarrhea, malaria, measles, and malnutrition) which in the past were generally considered and treated separately. PAHO estimates, that these conditions are responsible for the majority of child deaths in Latin America. Research demonstrates that most ill children suffer from more than one condition and the integrated approach to their diagnosis and treatment ensures that all their symptoms receive treatment while combining therapy in some cases, therefore providing optimal care. More recently the IMCI approach has evolved into three components: improvements in the case management skills of health staff through the provision of locally adapted guidelines on integrated management of childhood illness and activities to promote their use; improvements in the health system required for effective management of childhood illness; and improvements in family and community practices.

In response to the child survival challenge in Latin America and the Caribbean, staff from USAID, the Pan American Health Organization (PAHO) and the Partnership for Child Health Care Inc., the Cooperating Agency which implements the Basic Support for Institutionalizing Child Survival Project (BASICS) collaborated on the design of a five year LAC Regional IMCI strategy. This strategy was planned to improve child health services thereby reducing, the impact of the main causes of child mortality and morbidity in the LAC region.

The LAC Initiative focuses on this integrated approach primarily to reduce child morbidity and mortality but also to promote greater efficiency. IMCI promotes an integrated approach to sick childcare by advocating an integrated assessment of the child.

Inappropriate management of childhood illnesses wastes scarce resources. Although increased investment will be needed initially, eventually additional resources will not be required and the IMCI strategy will result in cost savings. During a time of decentralization and sector reform in health throughout the region, this integrated approach seems to work well.

The IMCI Initiative focuses on eight countries in the region where infant and under-five mortality rates remain high, among the countries in LAC where USAID, has PHN programs. Target countries of the IMCI results package include; Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, and Peru.

The five year Initiative was authorized on March 5, 1997 for a LOP of \$5 million. The planned allocation of funds was PAHO receiving approximately \$2,810,281 (plus up to an additional \$2,000,000 in potential add-ons from USAID country missions for related activities) and the BASICS I and II projects \$2,187,190.

Current plans are to increase the LOP to 55,722,000; no allocation between PAHO and BASICS has been determined.

The IMCI Initiative activities are grouped into phases: Design, Implementation, and Monitoring and Evaluation. Each target country will begin participation at various points within the framework depending on the commitment and capacity of the country to implement the IMCI strategy.

As a regional activity, the intent is that all activities be regional or sub-regional in scope. Funds allocated for regional activities in this proposal were not intended to be used for country-specific IMCI activities, in order not to impinge on mission prerogatives to fund and design country-specific activities

Implementing Roles

Because of its permanent intergovernmental nature in the region, PAHO assumes the overall coordinating role for the LAC Regional IMCI Initiative. PAHO and BASICS share implementation responsibility according to each partner's technical and organizational strengths. A lead agency has been agreed on by PAHO and BASICS for each proposed activity or group of activities. PAHO/BASICS regional activities are targeted at strengthening country-level IMCI capacity.

Results and Performance Indicators

The LAC Regional Strategic Objective of which IMCI is a component is *More Effective Delivery of selected Health Services and Policy*. In this case the selected health intervention is IMCI and the Strategic Objective for the IMCI Initiative is *More Effective Delivery of Child Health Services in Response to CDD, ARI, and Malnutrition*.

The Indicators to be used to measure progress in achieving the Strategic Objective for IMCI are the number of target countries—

- with 90% percent of Facilities in pilot districts delivering IMCI services; and
- with 10% of facilities delivering IMCI services.

Intermediate Results

IR 1: Country Health Leaders Have Information for IMCI Adoption;

IR 2: Country Plans and Strategies in Place for Introduction and Implementation of IMCI;

IR 3: Improved Country Capacity to Implement IMCI; and

IR 4: Monitoring and Evaluation Used to Adjust IMCI Program Plans.

Evaluation Objectives:

1. To determine if the results framework is still valid and feasible and to recommend adjustments to the results framework, design, and activities as appropriate.
2. To examine progress toward achieving the SO and IRs as planned, evaluating whether the results/intermediate results will be met in a timely and effective manner. To identify specific internal/external constraints which may limit their accomplishments or success and to recommend adjustments based on findings and conclusions
3. To assess how the initiative structure and design as configured is working including both the specific technical areas and activities and the delegation of responsibilities to the two partners as well as the working relationships and collaboration in the implementation of initiative activities. The team should recommend adjustments to implementation based on findings and conclusions
4. To assess the administration of the initiative by USAID and the two implementing partners including the status of coordination and communication within the organizations specifically between headquarters and field operations and host country governments and with USAID Washington and field missions.

Key questions to be answered:

The evaluation team should answer the following questions and make recommendations as to how USAID can improve and or strengthen the activity to increase the likelihood of achieving objectives/results as defined in these questions. Any changes to the questions listed below will be made within 2 days of signature of the amendment to the Task Order.

Results Framework

Does the Initiative's design and results framework (intermediate results or indicators) need to be changed or adjusted in any way? What recommendations does the evaluation team have about changes.

Are the human and material resources available appropriate to the size of the task? Are there too many target countries for adequate implementation? Are there too few target countries for regional impact? What is the most strategic use of the available resources to further the goal of reducing infant and child mortality through IMCI?

As a regional activity, the intent is that all activities be regional or sub-regional in scope. Country implementation is not included, in order not to impinge on mission prerogatives to fund and design country-specific activities. What has actually occurred and does the Initiative need to be modified in any way as a result?

Progress and Achievements

Has the initiative made good progress toward achievement of the IRs and results by successfully accomplishing specific activities as described in key project documents?

What progress to date has been made in influencing countries to adopt IMCI?

Have strategic plans been developed for beginning IMCI introduction and later implementation in countries? What is the quality of these plans and are they owned by host country governments?

Are there alternative models of IMCI introduction? How have these worked and what is the status in each country?

What is the status of implementation at the country level? Is there evidence that country training implementation has occurred where TOTs have been conducted? How has the quality of second and third generation training been effected? Have there been training impact follow-up studies? If so, how have the findings and results of these been used to modify training plans and other factors?

Have systems issues been addressed before training scale-up has occurred as articulated by WHO? What is the status of systems strengthening in each of the emphasis countries with respect to drug supply and to supervision? How has systems strengthening been addressed in each of the emphasis countries?

What is the value-added of this Initiative? What will it add to the world experience thus far in IMCI implementation?

Have any innovative approaches or tools been developed that have been adopted by others for use?

To date what is the status of monitoring and evaluation as a tool to improve implementation of IMCI by the country programs?

Initiative Structure

What are the strengths and weaknesses of the management structure as implemented? How responsive have the partners been to each other during the course of Initiative implementation?

To what extent are related structures functioning adequately? Have the IMCI national working groups been established in each country? Has the work of these groups moved the initiative forward in its achievement of the IRs?

Administration

As this project was planned to supplement county implementation through regional and sub-regional activities close collaboration with the USAID/LAC and Global Bureaus as well as field Missions was deemed essential in the Initiative's design. Has this collaboration with USAID at all levels occurred and if so has it been successful? Has the project leveraged additional resources for IMCI through this coordination?

How effective has the management and oversight of Initiative been by USAID/LAC? By G/ PHN/HN?

Is there good communication between headquarters and the field staff for both partner organizations? Is there good communication between partner staff and host country officials?

Have reports, work-plans, and other products been of adequate quality and submitted to USAID on time with appropriate levels of information?

Use of Resources

Have the project resources been used appropriately and effectively e.g. staff and other inputs? Has all planned staff been hired and have staff and job descriptions been approved by USAID as called for in the LAC/W grant to PAHO? In the task order/core contract with BASICS?

Materials and Procedures

1. Data Sources

The IMCI Initiative evaluation team will review relevant documentation including but not limited to the following: The IMCI Results package, Authorization, Grant to PAHO, R4s, Indicators paper, Memorandum of Understanding, Trip Reports, Six-month and Annual reports, Quarterly Financial Reports, Committee Reports (IMCI Working

Groups), IMCI Country-level Implementation plans, Training plans, Health Facilities Survey, Reports on Application of Health Facilities Survey Tool, Bolivia Training evaluation, Drug Assessment Tool, Reports of Donor Assessment tool application, and other project documents and publications. Interviews will be conducted with staff from USAID/LAC, USAID/G, PAHO, BASICS II, USAID field Missions, PAHO field Offices, PVOs involved with the initiative and the MOH

2. Methods of Data Collection

This will be primarily a process evaluation. The data will be collected through document review, key informant interviews, e-mail surveys, telephone interviews, field site visits and group discussions. The team will travel to three countries in the LAC region and interview field staff, MOH counterparts, USAID Mission and others involved with IMCI implementation.

3. Duration and Timing of the Evaluation and LOE

The IMCI Initiative evaluation will begin in November 30, 1999 or earlier if possible. Consultants should be approved to work Saturdays. The approximate time line envisioned is as follows:

Background documents distributed

Team Planning Meeting and Washington briefings

(Interviews USAID, PAHO, BASICS)

Team travels to Country 1

Team travels to Country 2

Team travels to Country 3

Washington, DC follow-up discussions, framing principal findings, and recommendations Brief USAID on principal findings and recommendations

Brief PAHO on principal findings and recommendations

Brief BASICS II on principal findings and recommendations

Draft report to USAID

USAID and partners comments on draft

Final report distributed

Team Composition

The evaluation team will consist of two members. The skills and experience listed below are necessary but may be fulfilled in a different team configuration than listed below:

1. A child survival specialist/Team Leader with knowledge of IMCI, policy, management systems, and strategic planning of child health programs in public sector institutions with, 10 years experience in design, implementation, and evaluation of USAID health programs. The person should have both field experience in Latin America and have an excellent knowledge of USAID/PHN strategic objectives. Experience with UN organizations and WHO or PAHO would also be helpful The

candidate should be fluent in Spanish (F.S. 3+-4) and have advanced writing skills in English.

2. A clinical and community training specialist with experience in national health training systems and evaluation in Latin America that is familiar with quality assurance and is fluent in Spanish (F.S.3+ -4) experience with USAID and UN, WHO or PAHO would also be helpful.

Funding and Logistical Support

All funding and logistical support for the assessment will be provided through this SO using a TASK Order to the MEDS project (Monitoring, Evaluation, and Design Services activity). Activities that will be covered include: recruitment of the team members, distribution of background documentation provided by USAID, arranging for travel and logistical support; secretarial and office assistance as needed, support for all personnel and business expenses related to the evaluation, assistance as required with editing, printing, and distributing the final report.

ANNEX F
EVALUATION SCHEDULE

WASHINGTON, D.C.

April 3–4	MEDS Office	Team Planning Meeting
April 5–7	Various Sites	Meetings (or telephone interviews) with MEDS and U.S.–based stakeholders: USAID (LAC, Global Bureau, Jamaica, former staff), PAHO, BASICS, RPM
April 8		Travel to Honduras

HONDURAS

April 9	Tegucigalpa	Document review and individual work
April 10	Tegucigalpa	Meetings with Dr. Miguel Dávila, PAHO/Honduras; Barry Smith, American Red Cross; CARE/Honduras, Proyecto Hogasa staff; Dr. Carlos Samayoa, PAHO Representative
April 11	Field Visit	Health Region 2–Director at MOH Regional Hospital, Comayagua; IMCI facilitator at MOH Area Hospital, La Paz; director and nurses at MOH Health Centers, Taulabé and Siguatepeque
April 12	Tegucigalpa	Meetings with Minister of Health; MOH IMCI team; Dr. Carlos Villabos, USAID/Honduras; Vicky Alvarado, BASICS; Dr. John Rogosch and Dr. Pinto, USAID/Honduras
April 13	Field Visit	Health Region 4–Choluteca; Director and teaching staff, CEDAR Nursing School, Choluteca; Director of MOH Health Centers, Comayagua; Sra. Amalia Sierra, Health Promoter, Pueblo Nueva Unión
April 14	Tegucigalpa	Development of notes from week in Honduras
April 15		Travel to the United States

UNITED STATES

April 17–28	New York	Telephone interviews with U.S.–based stakeholders: PAHO, World Bank, BASICS, USAID/LAC, USAID/Honduras, CORE group
April 19	New York	Meeting with Vincent Orinda, UNICEF

BOLIVIA

April 30		Travel to Bolivia
May 1		Rest
May 2		Meetings with Dr. Jaime Tellería and MOH IMCI team; Dr. Oscar Gonzalez, MOH; Dra. Ana Maria Aguilar and Dr. Dilberth Cordero, BASICS; Dra. Marta Mejía, PAHO; Dr. Fernando Lavadenz and Lic. Ma. Luisa Salinas, Unidad de Reforma de Salud; Dra. Remy Zumarán, IMCI Facilitator
May 3	Field Visit	Aroma District; directors and nurses at MOH Health Centers, Calamarca and Patacamaya; director and supervisor at MOH District Office
May 4	La Paz	Meetings with USAID/Bolivia; Dr. José Ignacio Carreño, PROCOSI; Dr. Andrés Bartos and staff, COTALMA
May 5		Telephone interview with Dra. Lillian Braun, Santa Cruz; meetings with Lic. Magaly de Yaly, UNICEF
May 6		Travel to Peru

PERU

May 7	Lima	Development of notes from week in Bolivia
May 8	Lima	Meetings with Dr. Luis Seminario, USAID/Peru; Dr. Miguel Dávila, PAHO; MOH National IMCI Coordinating Commission

May 9	Field Visit	Chiclayo: director and IMCI staff of MOH Regional Hospital, Chiclayo; directors and nurses at MOH Health Centers—El Bosque, Atusparia, Cerropan, Fernando Ortiz; mothers and health promoters at Health Center Fernando Ortiz
May 10	Field Visit	Piura: Director and IMCI staff of MOH Regional Hospital; director, nurses, mothers, and promoters at MOH Health Center Cura Mori
May 11	Field Visit	Sullana: Director and IMCI staff of MOH Regional Hospital; director and nurses at MOH Health Centers, Tambo Grande and Querecotillo; promoters at Locuto
May 12	Lima	Debriefing with MOH, PAHO, USAID/Honduras, UNICEF; development of notes from week in Peru
May 13–14		Travel to the United States

ANNEX G
DOCUMENTS REVIEWED

Basic Support for Institutionalizing Child Survival Project (BASICS). *1999 Report to the USAID Bureau for Latin America and the Caribbean for the Reporting Period of January 1–December 31, 1999.*

_____. *Tools Expo Catalog. A Summary of Tools for Improving Child Health.* (undated)

_____. LAC IMCI Initiative. Regional Achievement Summary. June 16, 1999.

_____. FY1997 Midyear Program Review—LAC Regional IMCI Initiative. June 12, 1997.

BASICS and CORE Group. *Reaching Communities for Child Health: Partnering with PVOs in Integrated Management of Childhood Illness (IMCI).* Proceedings of a workshop held at the Pan American Health Organization, Washington, D.C., February 24–26, 1999.

“IMCI pilot schemes successful in Kazakhstan,” *The Lancet*, Vol. 355, April 1, 2000.

Integrated Management of Childhood Illness (IMCI) in Countries of Latin America. Report of the meeting. Quito, Ecuador, January 27–29, 1998.

Lambrechts, T. and Salgado, R. Meeting Report of the BASICS II and WHO/CAH Coordination Meeting in Arlington, VA, January 24, 2000.

Letter from USAID to PAHO approving the grant, *Integrated Management of Childhood Illness Component.* May 20, 1997.

“Management of childhood illness in Africa,” *BMJ*, Vol. 320 :594-5, 2000.

Ministerio de Salud y Previsión Social. *Evaluación a Servicios de Salud en la Atención Integrada a las Enfermedades Prevalentes de la Infancia (AIEPI).* Primera Prueba Mundial, Bolivia, 12–30 de Abril de 1999.

_____. *Una Evaluación con Base en Indicadores. Evaluación de la Disponibilidad y Uso de Medicamentos para la Estrategia AIEPI.* Línea de Base. Bolivia. Mayo–Julio, 1998.

_____. *Atención Integrada a las Enfermedades Prevalentes de la Infancia (AIEPI).* Plan Nacional Bolivia, 1998. Año II de la Implementación, Fase de Expansión.

Our Joint Vision: Results of a Joint LAC/PAHO/BASICS Strategic Planning Workshop. November 1998.

Pan American Health Organization. PAHO/WHO's IMCI Technical Unit Report for the Project LAC Regional Results Package: Integrated Management of Childhood Illness, 1997–2001. January–December 1997.

Pan American Health Organization and Basic Support for Institutionalizing Child Survival. LAC Regional Results Package Integrated Management of Childhood Illness (IMCI) 1997–2001. A proposal to the Bureau for Latin America and the Caribbean, United States Agency for International Development. January 7, 1997.

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_____. LAC Integrated Management of Childhood Illness Results Package. *Semi-Annual Joint Progress Report to the USAID Bureau for Latin America and the Caribbean for the Reporting Period of January 1–July 30, 1998*. (undated)

_____. LAC Integrated Management of Childhood Illness Results Package. *1998 Report to the USAID Bureau for Latin America and the Caribbean for the Reporting Period of January 1–December 31, 1998*. December 6, 1999.

_____. LAC Integrated Management of Childhood Illness Results Package. *Semi-Annual Joint Progress Report to the USAID Bureau for Latin America and the Caribbean for the Reporting Period of January 1–July 30, 1999*. (undated)

_____. LAC Integrated Management of Childhood Illness Results Package. *1999 Report to the USAID Bureau for Latin America and the Caribbean for the Reporting Period of January 1–December 31, 1999*.

_____. *USAID/LAC Regional PAHO/BASICS IMCI Project Workplan and Budget, October 1, 1998 to December 31, 1999*. May 5, 1999.

_____. *USAID/LAC Regional PAHO/BASICS IMCI Project Workplan and Budget, October 1, 1998 to December 31, 2000*. December 1, 1999.

_____. LAC Regional IMCI Initiative. *Strategic Objective Performance and Cumulative Indicators*.

United States Agency for International Development. Results Review R2a. LAC Regional Program. FY 1999–2001. (undated)

_____. Results Review R2a. LAC Regional Program. FY 2000–2002. March 22, 2000.

World Health Organization. *IMCI Information Kit*. Geneva, September 1997.

_____. *Towards a Global Evaluation of the IMCI Strategy*. 1998.

ANNEX H
INTERVIEW LIST

Washington, D.C.

USAID

Carol Dabbs	Team Leader, LAC Regional Health Priorities Strategic
Marguerite Farrell	Senior Technical Adviser, LAC/RSD-PHN
Ellyn Ogden	CTO, Polio Eradication and Immunization Support
Sheila Lutjens	Jamaica USAID Representative
Al Bartlett	CTO of BASICS Project
Karen Cavanaugh	Health Systems Adviser, LAC/RSD-PHN
Melody Trott	Former USAID Technical Officer

PAHO

Dr. Gabriel Schmun	HCT Program Coordinator
Dr. Yehuda Benguigui	Regional Advisor IMCI
Christopher Drasbek	Regional Technical Adviser IMCI
Dr. José Antonio Solís	HPP Director

Management Sciences for Health

Douglas Keene	Deputy Director, RPM Project
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BASICS

David McCarthy	Technical Officer
Richard Nelson	LAC Operations Officer
Kim Cervantes	Technical Officer
Dr. Rene Salgado	Technical Officer

World Bank

Dr. Judy McGuire	Senior Nutritionist, LAC Region
Dr. Mariam Claeson	Principal Public Health Specialist

New York

Dr. Vincent Orinda	Senior Adviser, Child Health
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WHO Geneva

Dr. Thierry Lambrechts	Medical Officer, Monitoring and Evaluation
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HONDURASUSAID

John Rogosh	Director, Human Resources Development Office
Dr. Ernesto Pinto	Foreign Service National
Meri Sinitt	HPN Officer

Secretary of Health

Dr. Plutarco Castellanos	Secretary of Health
Dr. Jorge Humberto Meléndez	Head, Maternal and Child Health
Dra. María Elena Guevara	Officer in charge of IMCI activities
Leticia Castillo	Collaborates in IMCI activities

Region 2

Dr. Arturo Gutierrez	Regional Deputy Director
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Hospital Roberto Suazo Cordoba

Dr. Dignora Lizano	Pediatrician working with IMCI
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Centro de Salud Taulabé, Comayagua

Dr. María Isabel Degrand	Director
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Region 4, Escuela de Enfermería CERARH-Sur

Lic. Yolanda Echenique	Director
Lic. Ana Ester Vivas	Teacher

Centro de Salud La Providencia, Choluteca

Dra. Ana Silvia Muril	Director
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Pueblo Nueva Unión

Amalia Sierra	Health Promoter
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PAHO

Dr. Carlos Samayoa	Country Representative
Dr. Miguel Davila	Officer in charge of IMCI activities in the country

BASICS

Lic. Victoria Alvarado Country Representative

American Red Cross

Barry Smith Country Representative

CARE

Carmen Aleida Hernandez Manager, Project Hogasa
Francisco Almendares Deputy Manager, Project Hogasa

BOLIVIA

USAID

Susan Brems Chief, Health Section
Dr. Charles Oliver Deputy, Health Section
Dr. Oscar Gonzalez Former Manager, CCH Health Project

Ministry of Health

Dr. Jaime Tellerí Jefe, Unidad Nacional de Atención a las Personas
Dr. Fernando Lavadenz General Manager, Health Reform Unit
Dr. Remy Zubaran Pediatrician, Children's Hospital
Dr. Lilian Brunn Coordinator, Training Center

Children's Hospital, Santa Cruz

Dr. Andrés Bartos Director, COTALMA
Dr. Roxana Sauneno Pediatrician
Lic. Fatima Mariscal Nutritionist
Lic. Luz de la Fuente Nurse
Lic. Juana Siñani Nurse

PAHO

Dr. José Antonio Pagés Country Representative
Dr. Roberto Kriskovich Health Promoter
Dr. Martha Mejía Consultant, Child and Perinatal Health

BASICS

Dr. Ana María Aguilar Liendo Country Representative
Dr. Dilberth Cordero Consultant

Dr. Alberto Tenorio	Consultant
Dr. Adalid Zamora	Consultant

UNICEF

Magali de Yaly	Nutrition Officer
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Centro de Salud Calamarca, distrito Aroma

Dra. Dunia Arakaki	Director
Felipa Calle	Auxiliary Nurse

Centro de Salud de Patacamaya

Dr. Mónica Reyes	Director
Maruja López	Auxiliary Nurse
Maxima Zamora	Auxiliary Nurse
Sonia Laime	Auxiliary Nurse

Distrito Aroma, Department of La Paz

Dr. Mireya Elías	Director
Lic. Estela Vela	Health Services Supervisor

PROCOSI

Dr. José Ignacio Carreño	Director
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PERUUSAID

Dr. Luis Seminario	Director, Project 2000
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Ministry of Health

Dr. Jesus Toledo Tipo	Director, People's Health Unit
Dr. Fernando Cerna	Director, PAI and MCH Divisions

Chiclayo

Dr. Victor Linares Baca	Regional Director, Chiclayo
Dr. Luis Desa	Director, People's Health Unit
Llully Chumacero	Nurse, Clinical IMCI
Mirta Alvarado	Nurse, Community IMCI
Fredesbinda Diaz	Nurse, El Bosque Health Center

Dr. Victor Gonzalez
Dr. Jorge Ortiz Diaz
Dr. Jorge Postigo
Dr. William Guerrero

Director, Atusparia Health Center
Director, Cerropon Health Center
IMCI Facilitator
Director, Belen Hospital

Piura

Dr. Jorge Calderon Marti
Natalie Mendoza Faro
Violeta Romero
Dr. Max Rios

General Director
Nurse in charge of IMCI
Nurse in charge of PAI
Director, Cura Mori's Health Center

Plan International

Maria Espinoza Montenegro
Lilian Cabrera Villar
Javier Riofrio

Manager
Coordinator
Coordinator

Sullama

Gloria Ordoñez
Dr. Ehunice Vilchez Paredes
Jose Prieto Rivas
Estela Arroyo
Juana Calle
Dr. Carlos Rivas Jaramil
Ruth Villena

Nurse
Director, Tambo Grande Health Center
School Volunteer
Health Promoter
Health Promoter
Director, Querecotillo Health Center
Nurse

PAHO

Dr. Sonia Tavares
Dr. Miguel Dávila Dávila

Acting Country Representative
Officer in charge of IMCI Implementation

UNICEF

Dr. Mario Tavera Salazar

Health Technical Officer